M R-305

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(h)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 1

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital 6197-3 St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John Mills Gilbert (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southboro Arms St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 18 days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 6, 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fracture of left Femur

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 11/19/50 19.....

Where did Injury occur? Southboro, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? At Home (Specify type of place)

Manner of Injury Fall In His Room (How did injury occur?)

Nature of Injury Fracture of left femur

While at work? no Was autopsy performed? view

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Michael F. Burke, M.D., M. D.

(Address) Natick, Mass. Date 1/8/51 19.....

7 Rural Crematory Worcester, Mass. Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL January 9, 1951 19.....

8 NAME OF FUNERAL DIRECTOR Summer C. Gage

ADDRESS Marlboro, Mass.

Received and filed February 9 1951

John J. Walsh (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

11a If married, widowed, or divorced
HUSBAND of Mary S. Starr (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 82 Years 0 Months 22 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Clergyman (Retired) (Kind of work done during most of working life)

15 Industry or Business: Episcopal Church

16 Social Security No. .....

17 BIRTHPLACE (City) Chatham, N.J. (State or country)

PARENTS

18 NAME OF FATHER George Gilbert

19 BIRTHPLACE OF FATHER (City) Hartford, Conn. (State or country)

20 MAIDEN NAME OF MOTHER Amelia Mills

21 BIRTHPLACE OF MOTHER (City) Cannot be learned (State or country)

22 Informant Mrs. Mary S. Gilbert (Address) Southboro Arms, Southboro

A TRUE COPY.
ATTEST: Wm. J. Walsh (Registrar of City or Town where death occurred)

DATE FILED Jan. 10, 1951

ORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 10 2

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town); Westborough (City or town making return)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Melvina Trowbridge (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. Emp. St. Mark's School St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death - years 3 months 13 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan. 15, 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1950 to Jan. 15, 1951

I last saw her alive on Jan. 15, 1951 death is said to have occurred on the date stated above, at 11:00a m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Bronchopneumonia	5 days
ANTECEDENT CAUSES Due To (b) Generalized arteriosclerosis	years
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Psychosis with cerebral arteriosclerosis	4 months

Major findings:
Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....

(Signed) Diana L. Rodriguez M.D.
(Address) Westboro State Hospital Date Jan. 15 1951

6 St. Mary's Marlboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan. 17 1951

7 NAME OF FUNERAL DIRECTOR William M. Tighe
ADDRESS 3 Windsor St., Marlboro, Mass

Received and filed February 17 1951
John J. Rabesky
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	white	married

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of William Trowbridge
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Chamber Work (Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Marlborough (State or country) Mass.

PARENTS

17 NAME OF FATHER Frank Boivin

18 BIRTHPLACE OF FATHER (City)..... (State or country) cannot be learned

19 MAIDEN NAME OF MOTHER Rose Bouley

20 BIRTHPLACE OF MOTHER (City)..... (State or country) Canada

21 Informant Westborough State (Address) Hospital records

A TRUE COPY ATTEST: Bernard A. Dunn
(Registrar of City or Town where death occurred)

DATE FILED Jan. 22 1951

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate. If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physician to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m(h)-1-41-4695

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 3

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Turnpike Rd., (Fayville) St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

(City or town making return)

2 FULL NAME MILLAGE HARVEY BANKS
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran? If so, specify WAR) No

(a) Residence. No. Turnpike Rd., (Fayville) St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution — years months days. (Before death) (Specify whether)

In this community 78 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Mary E. MacLeod
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 79 Years 11 Months 13 Days | If loss than 1 day Hours Minutes

9 Usual Occupation: Retired Baker

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) Jordbrook (State or country) Nova Scotia

PARENTS

13 NAME OF FATHER John H. Banks

14 BIRTHPLACE OF FATHER (City) Jordbrook (State or country) Nova Scotia

15 MAIDEN NAME OF MOTHER Melissa Banks

16 BIRTHPLACE OF MOTHER (City) Jordbrook (State or country) Nova Scotia

17 Informant (Address) Mary MacLeod Banks (Widow) Turnpike Rd., Fayville — Relation, if any

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Jimothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Board of Health Jan 30, 1951
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH January 29 1951
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1947, to Jan 29 1951
I last saw him alive on January 29 1951, death is said to have occurred on the date stated above, at 3:00 p. m.

Immediate cause of death — Duration Important
Cardiac Failure — 2 days
Arterio-Sclerotic Heart Disease — 3 yrs.
Due to Embolism — 6 mo.
Due to Multiple Cerebral Thrombosis — 1 yr.
Generalized Arteriosclerosis — 3 yrs. Important
Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations no
Date of —
Of autopsy no
What test confirmed diagnosis? none

PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Jimothy P. Stone M. D.
(Address) Main St., Southboro Date Jan 29 1951

21 Maplewood Marlboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Feb 1 1951

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS 216 Main Ave., Marlboro

Received and filed February 1, 1951

A TRUE COPY ATTEST: John J. Rabeni (Registrar)

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12-49-900722

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 4

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Dwight Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Pitt H. Boynton (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 53 Main St. Belfast Maine (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence 20 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 10 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary Sclerosis

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19 .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Date 2-10 1951

7 Lincoln Cem. Lincoln Me. Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Feb 13, 1951 19 .....

8 NAME OF FUNERAL DIRECTOR Irving W. Hayden

ADDRESS 625 W. Main St. Westboro

Received and filed February 13 1951 (Registrar)

John F Fabee

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Divorced

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Laura Cloakedile (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 51 Years 1 Months 25 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Farmer (Kind of work done during most of working life)

15 Industry or Business: Dairy Farm

16 Social Security No. .....

17 BIRTHPLACE (City) (State or country) Prentiss Maine

PARENTS

18 NAME OF FATHER Harrison F Boynton

19 BIRTHPLACE OF FATHER (City) (State or country) Prentiss Maine

20 MAIDEN NAME OF MOTHER Mary Baker

21 BIRTHPLACE OF MOTHER (City) (State or country) Houlton Maine

22 Informant Pitt H. Boynton Jr. (Address) Mars Hill Maine

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Bd of Health (Official Designation) Feb 11 1951 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 51 5

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John T. Murray (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Melendy Rest Home (Usual place of abode) St. X Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 18 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 2, 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1951, to March 2, 1951

I last saw him alive on March 1, 1951 death is said to have occurred on the date stated above, at ..... m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Myocardial Degeneration

ANTECEDENT CAUSES Due To (b) Arteriosclerotic Heart Disease

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations.....

Date of operation..... Was autopsy performed? No

What test confirmed diagnosis? Clinical Findings

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Nicholas M. White, M. D.

(Address) Westboro, Mass. Date 3/2 1951

6 Immaculate Conception Marlboro (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL March 5, 1951

7 NAME OF FUNERAL DIRECTOR William M. Tighe

ADDRESS 3 Windsor St., Marlboro

Received and filed March 6 1951

James C Palermi

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	white	single

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years 0 Months 0 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired Shoe Worker (Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Atlohne (State or country) Ireland

PARENTS

17 NAME OF FATHER Michael Murray

18 BIRTHPLACE OF FATHER (City)..... (State or country) Ireland

19 MAIDEN NAME OF MOTHER Bridget Killion

20 BIRTHPLACE OF MOTHER (City)..... (State or country) Ireland

21 Informant Westborough State Hospital records (Address)

A TRUE COPY Samuel A. Dunne

ATTEST: ..... (Registrar of City or Town where death occurred)

DATE FILED March 7, 1951

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12-49-900722

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 6

PLACE OF DEATH
1 Worcester (County)
Southboro (City or Town)
No. Northboro Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lizzie C. Johnson
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Northboro Rd. St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 49 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 15 1951
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary Sclerosis

5 Accident, suicide, or homicide (specify).....
Date and hour of injury.....19.....
Where did Injury occur?.....
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)
Manner of Injury .....
(How did injury occur?)
Nature of Injury .....
While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No
If so, specify.....
(Signed) Walter F Mahoney, M. D.
(Address) Westborough Date Mar 15 1951

7 Rural Cemetery Southboro Mass.
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL March 19 1951

8 NAME OF FUNERAL DIRECTOR Timothy P. Stone
ADDRESS Westboro Mass.

Received and filed March 20 1951
John J Kelleher
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
female	white	Married

11a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of James B. Johnson
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 72 Years 2 Months 12 Days | If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business: own home

16 Social Security No. none

17 BIRTHPLACE (City) Cape Breton
(State or country) Nova Scotia

PARENTS

18 NAME OF FATHER John A. Campbell

19 BIRTHPLACE OF FATHER (City) Cape Breton
(State or country) Nova Scotia

20 MAIDEN NAME OF MOTHER Annie Patterson

21 BIRTHPLACE OF MOTHER (City) Cape Breton
(State or country) Nova Scotia

22 Informant James B. Johnson
(Address) Northboro Rd. Southboro Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Bd of Health 3-19-51
(Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 12 8

1 PLACE OF DEATH: Middlesex (County) — Ashland (City or Town) — Ashland (City or town making return)

No. Mary Jane Re[illegible]t Home Central St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William James Collins
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Road St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years ... months ... days. In place of residence 30 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Mar (Month) 19 (Day) 1951 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1950, to Mar 19, 1951

I last saw h[illegible] im alive on March 18 51 death is said to have occurred on the date stated above, at 5.25 A m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

ANTECEDENT CAUSES Due To (b) Cancer of prostate — 1xyrs

Due to (c) generalized arteriosclerosis 2 yrs
cerebral softening &thromboses — 1 yr

OTHER SIGNIFICANT CONDITIONS: none

Major findings: Of operations: none

Date of operation: Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Timothy P Stone, M. D.

(Address) Southboro Mass Date 3/20/51

6 Place of Burial or Cremation: St. Joseph's Cemetery (City or Town) Lynn

DATE OF BURIAL Mar 21 19 51

7 NAME OF FUNERAL DIRECTOR: John W. Sullivan

ADDRESS 378 Lincoln St Marlboro

Received and filed April 16 1951

John E. Baker
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male | 9 COLOR OR RACE: white | 10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): widowed

10a If married, widowed, or divorced HUSBAND of: Fanny Jane Sullivan
(Give maiden name of wife in full)

(or) WIFE of:
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years 6 Months 20 Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Shoemaker retired
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. none

16 BIRTHPLACE (City) Hopkinton
(State or country) Mass

PARENTS

17 NAME OF FATHER: John Collins

18 BIRTHPLACE OF FATHER (City): Ireland
(State or country)

19 MAIDEN NAME OF MOTHER: Catherine Donovan

20 BIRTHPLACE OF MOTHER (City): Ireland
(State or country)

21 Informant: Mrs Mary E Burke
(Address) Southville Mass

A TRUE COPY.
ATTEST: XXXXX
(Registrar of City or Town where death occurred)

DATE FILED Mar 21 19 51

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK. — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 9

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Edgell Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Churchill Allen (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Flag Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 5 wks. days. In place of residence 36 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 20, 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 10, 1950, to March 20, 1951

I last saw him alive on March 13, 1951 death is said to have occurred on the date stated above, at 7:00 p.m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Acute coronary insufficiency — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES Due To (b) Arteriosclerotic heart disease — years

Due To (c)

OTHER SIGNIFICANT CONDITIONS: none

Major findings: Of operations:

Date of operation: Was autopsy performed? no

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) H.M. Levenson, M.D. M. D.

(Address) Framingham, Mass. Date 3/21/51 19

6 North Burial Ground, Providence, RI Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 24, 1951 19

7 NAME OF FUNERAL DIRECTOR Sumner Gage

ADDRESS Cotting Ave., Marlboro, Mass.

Received and filed April 19 1951

John J. Rabbett (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Single

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years 9 Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Farmer (Kind of work done during most of working life)

14 Industry or Business: Self-employed

15 Social Security No.

16 BIRTHPLACE (City) Providence, R.I. (State or country)

PARENTS

17 NAME OF FATHER Crawford Allen

18 BIRTHPLACE OF FATHER (City) Providence, R.I. (State or country)

19 MAIDEN NAME OF MOTHER Clara D. Eaton

20 BIRTHPLACE OF MOTHER (City) Providence, R.I. (State or country)

21 Informant Mr. Harris Eaton (Address) Flag Rd., Southboro, Mass.

A TRUE COPY ATTEST: Wm. J. Walsh (Registrar of City or Town where death occurred)

DATE FILED March 21, 1951 19

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 16

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

No. School St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ella Rosanna Haynes Sawin
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 38 Hemenway St. St. Boston
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death July 21, 1950 years ..... months ..... days. In place of residence 2 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: March 28 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 28, 1951 to March 28, 1951

I last saw her alive on March 28, 1951, death is said to have occurred on the date stated above, at 10:25 p.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) Cerebral Sclerosis Heart Disease	few years
ANTECEDENT CAUSES	Due To (b)	
	Due To (c)	
OTHER SIGNIFICANT CONDITIONS		

Major findings:
Of operations .....
Date of operation ..... Was autopsy performed? .....
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Albert E. Letourneau M. D.
(Address) Marlboro Date March 29, 1951

6 Rockland Marlboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 31 1951

7 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS 15-21 Bolling Ave., Marlboro

Received and filed March 29, 1951
John J. Rabbett (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of John Vinal Sawin
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years 6 Months 19 Days | If under 24 hours .....Hours .....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. .....

16 BIRTHPLACE (City) North Sudbury
(State or country) Mass.

PARENTS

17 NAME OF FATHER Reuben Haynes

18 BIRTHPLACE OF FATHER (City) North Sudbury
(State or country) Mass

19 MAIDEN NAME OF MOTHER Esther Louise Dunham

20 BIRTHPLACE OF MOTHER (City) Erie
(State or country) Pennsylvania

21 Informant Mrs Geo. Bagg
(Address) Witherbee St., Marlboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Bd of Health 3-29-51
(Official Designation) (Date of Issue of Permit)

50m-(a)-11-49-900,560

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 11

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. 87 Brigham St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elija Mulvey Stone (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 87 Brigham St. (Usual place of abode) — (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: March (Month) 30 (Day) 1951 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March, 1949, to March 30, 1951. I last saw her alive on March 30, 1951, death is said to have occurred on the date stated above, at 9:30 p.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) Cerebral Hemorrhage.	24 hrs.
ANTECEDENT CAUSES	Due To (b) Generalized arteriosclerosis	?
	Due To (c)	
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations.....

Date of operation..... Was autopsy performed? No.

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? No.

If so, specify.....

(Signed) [illegible] M. D.

(Address) Westboro, Mass. Date 3/31/1951

6 Immaculate Conception Cem. Marlboro. Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 2, 1951

7 NAME OF FUNERAL DIRECTOR John P. Rowe

ADDRESS 57 Main St. Marlboro

Received and filed April 3 1951

John J. Rafferty (Registrar)

50M (D)-6-50-902253

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female | 9 COLOR OR RACE: White | 10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Frank James Stone
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. —

16 BIRTHPLACE (City) (State or country) County Letrim Ireland

PARENTS

17 NAME OF FATHER: Frank Mulvey

18 BIRTHPLACE OF FATHER (City) (State or country): County Letrim Ireland

19 MAIDEN NAME OF MOTHER: Mary Quinn

20 BIRTHPLACE OF MOTHER (City) (State or country): County Letrim Ireland

21 Informant (Address): Mrs. John Finn - daughter, 87 Brigham St, Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) 4-1-51 (Date of Issue of Permit)

FORM R-301A

M & 24444

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 12

1 PLACE OF DEATH: Worcester (County) — Southborough (City or Town)

No. Malboro Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Greta Isabelle (Bailey) Main
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No.

(a) Residence. No. Malboro Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 3 months ..... days. In place of residence 2 years 3 months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: April (Month) 24 (Day) 1951 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Apr 14, 1951 to Apr 24, 1951

I last saw her alive on Apr 24, 1951, death is said to have occurred on the date stated above, at 1 P m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Cerebral Thrombosis	10 days
ANTECEDENT CAUSES Due To (b)	Arteriosclerosis	2 1/2 yrs
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Diabetes Mellitus	10 yrs

Major findings:
Of operations

Date of operation ..... Was autopsy performed? .....

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Penelope H Ingalls, M. D.
(Address) Southboro Date Apr 24 1951

Oak Grove Cemetery, West Haven Conn.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Friday - April 27 1951

7 NAME OF FUNERAL DIRECTOR Robert K. Wadsworth
ADDRESS 108 LINCOLN ST. Framingham. Mass.

Received and filed April 30 1951
John J. Baleen
(Registrar)

100M-(D)-10-48-24858

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Walter Raymond Main
(Husband's name in full)

11 IF STILLBORN, enter that fact here. —

12 AGE 62 Years 2 Months 9 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At Home - Housework
(Kind of work done during most of working life)

14 Industry or Business: —

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Milford Connecticut

PARENTS

17 NAME OF FATHER George Edward Bailey

18 BIRTHPLACE OF FATHER (City) Thomaston
(State or country) Connecticut

19 MAIDEN NAME OF MOTHER Minnie Pardee

20 BIRTHPLACE OF MOTHER (City) West Haven
(State or country) Connecticut

21 Informant Mrs. Walter J. Badger III (daughter)
(Address) Malboro Road - Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent Bd of Health 4-26-51
(Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 103 13

1 PLACE OF DEATH: Worcester (County); Westboro (City or Town)

No. Houghton Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Gertie Ida Titus (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Valley Road St. Fayville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 16 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 29, 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 1951, to April 29, 1951

I last saw her alive on Apr. 28, 1951, death is said to have occurred on the date stated above, at 4.30 p.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	myocardial failure	4-5 days
ANTECEDENT CAUSES Due To (b)	chronic myocarditis	months
Due To (c)	generalized arteriosclerisos	yrs
OTHER SIGNIFICANT CONDITIONS	paralysis agitans	yrs

Major findings: Of operations not done

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis? clinical course

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) James G. Boyd, M. D.

(Address) Westboro, Mass. Date 4/29 1951

6 Rural Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 1, 1951

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage

ADDRESS 15-21 Cotting Ave., Marlboro

Received and filed May 1 1951

John J. Rabbeni
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR OR RACE: white

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): widowed

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of William H. Titus
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years 4 Months 9 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No.....

16 BIRTHPLACE (City) Southboro
(State or country) Mass.

PARENTS

17 NAME OF FATHER: Abraham Hyde

18 BIRTHPLACE OF FATHER (City) Sutton
(State or country) Mass.

19 MAIDEN NAME OF MOTHER: Angelina E. Walker

20 BIRTHPLACE OF MOTHER (City) Hancock
(State or country) N. H.

21 Informant Clarence J. Hyde
(Address) 10 Norwood St., Marlboro

A TRUE COPY
ATTEST: Anne A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED April 30 1951

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 17

1 PLACE OF DEATH: (County) ..... (City or Town) Foxvale

No. Pleasant St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Victoria L. Baldelli Travaglini (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Pleasant St. (Usual place of abode) (If nonresident, give city or town and State) .....

Length of stay: In place of death .....years .....months .....days. In place of residence 50 years .....months .....days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: MAY (Month) 2 (Day) 1951 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 19, 1948, to May 2, 1951

I last saw her alive on May 2, 1951, death is said to have occurred on the date stated above, at 5:48 P.M.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) Cerebral Hemorrhage	12 hrs.
ANTECEDENT CAUSES	Due To (b) Hypertension + Arterio-sclerosis.	5 yrs
	Due To (c) —	
OTHER SIGNIFICANT CONDITIONS	—	

Major findings: Of operations: none

Date of operation: — Was autopsy performed? no

What test confirmed diagnosis? clinical diagnosis

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Timothy P. Stone, M. D.

(Address) Main St., Southboro Date May 3, 1951

6 Rural Cemetery Southboro Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 5 1951

7 NAME OF FUNERAL DIRECTOR Dessieu & Ledoux

ADDRESS 457 Lincoln St Worcester Mass

Received and filed May 7 1951

John J. Flaherty
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Joseph Baldelli (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years 4 Months .....Days. If under 24 hours .....Hours .....Minutes

13 Usual Occupation: at Home (Kind of work done during most of working life)

14 Industry or Business: at Home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) San Giorgio Peano Italy

PARENTS

17 NAME OF FATHER Andrew Travaglini

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Unknown

20 BIRTHPLACE OF MOTHER (City) (State or country) .....

21 Informant Miss Sara Baldelli
(Address) Pleasant St Shrewsbury Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) May 3, 1951 (Date of Issue of Permit)

50m-(a)-11-49-900,560

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

WORCESTER (City or town making return)

Registered No. 1

1 PLACE OF DEATH: WORCESTER (County); WORCESTER (City or Town)

No. The Memorial Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Rena E (Dandro) Stimson (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. - Southville Rd St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence ..... years ..... months ..... days.

17 hrs 15 min

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 7 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 4, 1951 to May 7, 1951

I last saw her alive on May 7, 1951 death is said to have occurred on the date stated above, at 6.00 A m.

INTERVAL BETWEEN ONSET AND DEATH: ?

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Malignant left frontal brain tumor

ANTECEDENT CAUSES (b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations no op.

Date of operation ..... Was autopsy performed? yes

What test confirmed diagnosis? -

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) C C Schofield, M. D.

(Address) Worcester Date 5/7 1951

6 Hope Cem Worcester
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 10 1951

7 NAME OF FUNERAL DIRECTOR George Sessions for Geo Sessions Sons

ADDRESS Worcester

Received and filed June 7 1951

John J Raben
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Walter K Stimson Sr (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 52 Years 10 Months 23 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At Home (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Worcester (State or country)

PARENTS

17 NAME OF FATHER Moses Dandro

18 BIRTHPLACE OF FATHER (City) --- (State or country) Vt

19 MAIDEN NAME OF MOTHER Mary L LaFleur

20 BIRTHPLACE OF MOTHER (City) Worcester (State or country)

21 Informant Walter K Stimson Sr (Address) Southboro

A TRUE COPY
ATTEST: Madeline M. Midgley
(Registrar of City or Town where death occurred)

DATE FILED May 10 1951, Asst.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Louise Ware Henry (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) 16

(a) Residence. No. Oak Hill Road St. Fayville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence 2 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 11, 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 9, 1951, to May 11, 1951

I last saw her alive on May 11, 1951, death is said to have occurred on the date stated above, at 3:55 P. m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) Cerebral thrombosis	2½ days.
ANTECEDENT CAUSES	Due To (b) Arteriosclerosis, generalized, with hypertension	5 yrs.
	Due To (c)	
OTHER SIGNIFICANT CONDITIONS	none	

Major findings: Of operations: none

Date of operation ..... Was autopsy performed? no

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify no

(Signed) Timothy P. Stone, M. D.

(Address) Southboro, Mass. Date 5/11/ 1951

6 East View, Wadesboro, N. C. Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 14, 1951 19

7 NAME OF FUNERAL DIRECTOR Frederick A. Cookson

ADDRESS Framingham, Mass.

Received and filed June 9 1951

John J. Rabemi (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of T. Ray Henry (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 58 Years 3 Months 21 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Thomasville, N. C.

PARENTS

17 NAME OF FATHER Frank D. Ware

18 BIRTHPLACE OF FATHER (City) (State or country) North Carolina

19 MAIDEN NAME OF MOTHER Myrtle Leach

20 BIRTHPLACE OF MOTHER (City) (State or country) North Carolina

21 Informant Mrs. Wm. Hayward (Address) Oak Hill Rd., Fayville

A TRUE COPY. ATTEST: Wm. A. Walsh (Registrar of City or Town where death occurred)

DATE FILED May 16, 1951

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Westborough 17
(City or town making return)

Registered No. 114

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Eugene Clark
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Marlboro Road St. x Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 4 years 9 months 11 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 16, 1951
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1947, to May 16, 1951

I last saw him alive on May 15, 1951 death is said to have occurred on the date stated above, at 8:20 a.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Bronchopneumonia	3 days
ANTECEDENT CAUSES Due To (b) Right Hemiplegia	
Due To (c) Hypertensive, Arteriosclerotic Heart Disease	
OTHER SIGNIFICANT CONDITIONS	

Major findings:
Of operations.....
Date of operation..... Was autopsy performed? No
What test confirmed diagnosis? Clinical Findings

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify.....
(Signed) Nicholas M. White, M. D.
(Address) Westboro, Mass Date May 16, 1951

6 Evergreen Cemetery, Stoughton
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 19 1951

7 NAME OF FUNERAL DIRECTOR Lowe & Powers
ADDRESS Stoughton

Received and filed June 13, 1951
John J. Patenaude
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Separated

10a If married, widowed, or divorced HUSBAND of Minnie T. Burrell
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years 9 Months 11 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Printer
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Phoenix
(State or country) Rhode Island

PARENTS

17 NAME OF FATHER Luther Clark

18 BIRTHPLACE OF FATHER (City) Stoughton
(State or country)

19 MAIDEN NAME OF MOTHER Mary E. Richards

20 BIRTHPLACE OF MOTHER (City) cannot be learned
(State or country)

21 Informant Westborough State
(Address) Hospital records

A TRUE COPY
ATTEST: Daniel A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED May 17, 1951

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH (City or town making return) 18

Registered No. 96 92

1 PLACE OF DEATH: MIDDLESEX (County); MARLBOROUGH (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Hollis H. Fairbanks (If married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Cordaville Road (Usual place of abode) Southboro, Mass (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 22 days. In place of residence 20 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 23, 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Apr. 10, 1949 to May 23, 1951

I last saw him alive on May 23, 1951, death is said to have occurred on the date stated above, at 2.10 P.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Sclerotic heart disease	2 mo
ANTECEDENT CAUSES Due To (b) arteriosclerosis	Yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Arthritis	3 ys

Major findings: Of operations none

Date of operation ..... Was autopsy performed? .....

What test confirmed diagnosis? Examination

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) C.W. Smith, M. D.

(Address) Marlborough Date 5-2 -51 19....

6 Rural Place of Burial or Cremation Southboro (City or Town)

DATE OF BURIAL May 26, 1951 19....

7 NAME OF FUNERAL DIRECTOR Sumner C. Tape

ADDRESS Marlborough, Mass

Received and filed June 13 1951

John J. Rabene

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	W	Married

10a If married, widowed, or divorced HUSBAND of Lottie E. Hollis (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 9 Months 2 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Retired- manager (Kind of work done during most of working life)

14 Industry or Business: Store Gen. Mdse

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Hopkinton, Mass

PARENTS

17 NAME OF FATHER Henry A. Fairbanks

18 BIRTHPLACE OF FATHER (City) (State or country) Shrewsbury, Mass

19 MAIDEN NAME OF MOTHER Anna Kinder

20 BIRTHPLACE OF MOTHER (City) (State or country) Westboro, Mass

21 Informant (Address) Lottie H. Fairbanks, Southboro, Mass

A TRUE COPY, ATTEST: F. J. Bertrand

(Registrar of City or Town where death occurred)

DATE FILED ..... 19....

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 15

1 PLACE OF DEATH: (County) Middlesex; (City or Town) Ashland; No. Mary Jane Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Walter E. Dunn (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Parkerville Rd St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death .....years .....months .....days. In place of residence 20 years .....months .....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: May (Month) 27 (Day) 1951 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1937, to May 27, 1951, I last saw h. alive on May 26, 1951, death is said to have occurred on the date stated above, at 3:15 A m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Cancer of bladder (Urinary)	1 yr
ANTECEDENT CAUSES (b) Due To		
(c) Due To		
OTHER SIGNIFICANT CONDITIONS	A-S. heart disease & Congestive failure	2 yrs

Major findings: Of operations .....

Date of operation ..... Was autopsy performed? .....

What test confirmed diagnosis? Cystoscopy + biopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Hugh Folsom M. D.

(Address) Framingham Date 5-28 1951

6 Rural Cemetery Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 29 1951

7 NAME OF FUNERAL DIRECTOR C. Ronald Merriam

ADDRESS 173 Union Ave Framingham

Received and filed June 27 1951

John L. Baker
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male | 9 COLOR OR RACE White | 10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) married

10a If married, widowed, or divorced HUSBAND of Eva J. Cameron (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years 9 Months 12 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Shipper - retired (Kind of work done during most of working life)

14 Industry or Business: Hunt & Rankin Co. - Boston

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Boston Mass

PARENTS

17 NAME OF FATHER James H. Dunn

18 BIRTHPLACE OF FATHER (City) (State or country) Boston Mass

19 MAIDEN NAME OF MOTHER Margaret Hilling

20 BIRTHPLACE OF MOTHER (City) (State or country) Bath Maine

21 Informant (Address) Mrs. Eva Dunn - wife Southboro, Mass

A TRUE COPY.

ATTEST: Francis W. Fills
(Registrar of City or Town where death occurred)

DATE FILED May 29 1951

FORM R-301A

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Fayville (City or Town) — No. Turnpike Road, St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Carrie Greenwood Smith (Burnell) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) 19

(a) Residence. No. Turnpike Rd., St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death .....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: May (Month) 30 (Day) 1951 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 13, 1951, to May 30, 1951

I last saw her alive on May 28, 1951, death is said to have occurred on the date stated above, at 4:30 A. m.

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Bulbar Paralysis	1 week
ANTECEDENT CAUSES Due To (b)	Multiple Cerebral Thromboses	2 years
Due To (c)	Arteriosclerosis, generalized	8 years
OTHER SIGNIFICANT CONDITIONS	—	—

Major findings: Of operations: none

Date of operation: none Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Timothy P. Stone, M. D.

(Address) Main St., Southboro Date 5-30 1951

6 Edgell Grove Cem., Framingham
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 1, 1951

7 NAME OF FUNERAL DIRECTOR John P. Rowe

ADDRESS Marlboro. Mass.

Received and filed June 1, 1951

John J. Baker
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Robert Steele Smith
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 11 Months 28 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. —

16 BIRTHPLACE (City) Woolwich (Wood FORD) (State or country) Maine

PARENTS

17 NAME OF FATHER Edward Burnell

18 BIRTHPLACE OF FATHER (City) (State or country) Maine

19 MAIDEN NAME OF MOTHER Alice Buckley

20 BIRTHPLACE OF MOTHER (City) (State or country) Maine

21 Informant Mrs. Edwina McGovern - daughter
(Address) Turnpike Rd. Fayville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of Health
(Official Designation)

5-31-51
(Date of Issue of Permit)

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

100M-(D)-10-48-24858

FORM R-303

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. chap. 46, section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

50m-(c)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 20

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret Nugent (If deceased is a married, widowed or divorced woman, give also maiden name.)

Physician — Important (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 80 West Main St. Marlboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or Institution ..... years ..... months ..... days. In this community ..... yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 80 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Box Builder

10 Industry or Business: Wedgewood Mfg Co.

11 Social Security No. 032-20-8992

12 BIRTHPLACE (City) (State or country) Marlboro Mass

PARENTS

13 NAME OF FATHER: Lawrence Casey

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Margaret McTague

16 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

17 Informant: Mrs Frank King (Relation, if any: Niece)
(Address) 80 West Main St. Marlboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Board of Health 6-5-51
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: June (Month) 4 (Day) 1951 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably coronary thrombosis

20 Accident, suicide, or homicide (specify) .....

Date of occurrence ..... 19 .....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....

Nature of Injury .....

While at work? ..... Was there an autopsy? No

21 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Walter J Mahoney, M. D.

(Address) Westborough Date June 4 1951

22 Immaculate Conception Marlboro
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL June 7, 1951

23 NAME OF FUNERAL DIRECTOR John J Powers & Son

ADDRESS 93 Main St. Marlboro

Received and filed June 7, 1951

A TRUE COPY ATTEST: John J Rabeni
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. 21

1 PLACE OF DEATH: Middlesex (County) Framingham (City or Town)

No. Framingham Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anna Suskie
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Newton St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 2 months ..... days. In place of residence ..... years 3 months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 7, 1951
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 26, 1951 to June 7, 1951

I last saw her alive on June 6, 1951, death is said to have occurred on the date stated above, at 2:05AM m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral thrombosis	34hrs.
ANTECEDENT CAUSES (b) Due To Arteriosclerosis Generalized	10yrs.
(c) Due To Age and diabetes mellitus	10yrs.
OTHER SIGNIFICANT CONDITIONS	

Major findings:
Of operations.....
Date of operation..... Was autopsy performed? no
What test confirmed diagnosis? Clinical diagnosis

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) Timothy P. Stone
(Address) Southboro, Mass. Date June 7, 1951

6 St. Joseph's Cem., Lynn, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 7, 1951

7 NAME OF FUNERAL DIRECTOR Thomas W. Rhodes
ADDRESS Lynn, Mass.

Received and filed July 12, 1951
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Thomas Suskie
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 63 Years 6 Months 3 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No.....

16 BIRTHPLACE (City) Poland
(State or country)

PARENTS

17 NAME OF FATHER John Farat

18 BIRTHPLACE OF FATHER (City) Poland
(State or country)

19 MAIDEN NAME OF MOTHER Cannot be learned

20 BIRTHPLACE OF MOTHER (City) Poland
(State or country)

21 Informant (Address) Josephine Pietrasiak Newton St., Southboro, Mass.

A TRUE COPY.
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED June 8, 1951

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

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50m-(c)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 27

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Edgell Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Julia A. Eagan (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Road St. Fayville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 6 months 6 days. In place of residence 14 years 7 months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 10, 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 25, 1948 to June 20, 1951

I last saw her alive on June 16, 1951 death is said to have occurred on the date stated above, at 11:00AM.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Carcinoma of Stomach	6mos.
ANTECEDENT CAUSES Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Generalized Arteriosclerosis	5yrs.

Major findings: Of operations none

Date of operation None Was autopsy performed? no

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Timothy P. Stone M. D.

(Address) Southboro, Mass. Date June 21, 1951

6 St. Stephen's Framingham, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 23, 1951

7 NAME OF FUNERAL DIRECTOR Eugene J. McCarthy

ADDRESS 11 Lincoln St., Framingham

Received and filed July 10, 1951

Robert J. Robeni (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Single

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years 3 Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Housework (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No.

16 BIRTHPLACE (City) Framingham, Mass. (State or country)

PARENTS

17 NAME OF FATHER Owen Eagan

18 BIRTHPLACE OF FATHER (City) New York City (State or country)

19 MAIDEN NAME OF MOTHER Ellen Hefferman

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant Mrs. Earl Smiddy (Address) Turnpike Rd., Fayville, Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED June 25, 1951

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 23

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Girl Peters (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 5 Wood Street St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 2 days. In place of residence ....years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 12, 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 10, 1951, to June 12, 1951

I last saw her alive on June 12, 1951, death is said to have occurred on the date stated above, at 3:25PM m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) Prematurity	2days
ANTECEDENT CAUSES (b) Due To	
(c) Due To	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation.....Was autopsy performed? no

What test confirmed diagnosis? Examination

5 Was disease or injury in any way related to occupation of deceased? no If so, specify.....

(Signed) Edward J. Moynihan M. D.

(Address) Framingham, Mass. Date 6/13/51

6 St. Stephen's Cemetery Framingham Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 14, 1951

7 NAME OF FUNERAL DIRECTOR Henry C. Boyle, Jr.

ADDRESS Framingham, Mass.

Received and filed July 10 1951

Robert J. Baker (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Single

10a If married, widowed, or divorced HUSBAND of..... (Give maiden name of wife in full)

(or) WIFE of..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE .....Years .....Months 2 Days | If under 24 hours .....Hours .....Minutes

13 Usual Occupation:..... (Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Southville, Mass. (State or country)

PARENTS

17 NAME OF FATHER Raymond R. Peters

18 BIRTHPLACE OF FATHER (City) West Berlin, (State or country) Vermont

19 MAIDEN NAME OF MOTHER Gertrude Socco

20 BIRTHPLACE OF MOTHER (City) Millville, Mass. (State or country)

21 Informant Mr. R. R. Peters (Address) Southville, Mass.

A TRUE COPY.

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED June 15, 1951

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. 24

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Cushing VA Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Howard R. Lincoln
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW I

(a) Residence. No. Pearl Street St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 4 days. In place of residence ....years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 16, 1951
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 12, 1951 to June 16, 1951

I last saw him alive on June 16, 1951, death is said to have occurred on the date stated above, at 11:00AM.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Hypertensive Cardio Vascular Disease	lyr.
ANTECEDENT CAUSES Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Rt. lower lobe pneumonia	lwk.

Major findings: Of operations.....

Date of operation.....Was autopsy performed? no

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....

(Signed) Frank J. Keffustan II, M. D.

(Address) Cushing VA Hosp. Date 6/16/51

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 19, 1951

7 NAME OF FUNERAL DIRECTOR Seymour O. Wood

ADDRESS Hopkinton, Mass.

Received and filed July 10 1951

John J. Baleme
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced HUSBAND of Allene Voter
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 61 Years 6 Months 23 Days | If under 24 hours ....Hours....Minutes

13 Usual Occupation: Grocer self-employed
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) (State or country) Southboro, Mass.

PARENTS

17 NAME OF FATHER Paul Lincoln

18 BIRTHPLACE OF FATHER (City) (State or country) Littleton, Mass.

19 MAIDEN NAME OF MOTHER Clara Hill

20 BIRTHPLACE OF MOTHER (City) (State or country) S. Paris, Maine

21 Informant (Address) Allene Lincoln, Pearl St. Southboro, Mass.

A TRUE COPY.
ATTEST: Wm. A. Walsh
(Registrar of City or Town where death occurred)

DATE FILED June 21, 1951

Date of entering Military Service	October 5, 1917
Date of Discharge	July 15, 1919
Rank, Rating	P.F.C.
Service Number	1666835

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH (City or town making return)

Registered No. 115 25

1 PLACE OF DEATH: MIDDLESEX (County) — MARLBOROUGH (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Caroline E. Sherret (McDonald)
(If deceased was married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. (Usual place of abode) Newton St Southboro, Mass
(If nonresident, give city or town and State)

Length of stay: In place of death 1 year 18 months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 3, 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 9, 1949 or 19, to July 3, 1951, 19
I last saw h alive on July 3, 1951 at 7.49 P.M., death is said to have occurred on the date stated above, at m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinomatosis recurrent from carcinoma cervix — INTERVAL BETWEEN ONSET AND DEATH 2 yr

ANTECEDENT CAUSES Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Carcinoma cervix
Of operations Apr. 1949 no
Date of operation Was autopsy performed?
What test confirmed diagnosis? path. section
no

5 Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) John J. Lepore M.D. July 4, 1951
(Address) Marlboro Date 19

6 Rural Southboro, Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 7, 1951 19

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS Marlborough, Mass

Received and filed July 9, 1951
August 2 19 51
John J. Baldini
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	W	Married

10a If married, widowed, or divorced
HUSBAND of James R. Sherret (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 46 Years 4 Months 23 Days — If under 24 hours Hours Minutes

13 Usual Occupation: Head laundress (Kind of work done during most of working life)

14 Industry or Business: St. Mark's School

15 Social Security No.

16 BIRTHPLACE (City) (State or country) East Weymouth, Mass

PARENTS

17 NAME OF FATHER Frank MacDonald

18 BIRTHPLACE OF FATHER (City) (State or country) Weymouth, Mass

19 MAIDEN NAME OF MOTHER Emma E. Phipps

20 BIRTHPLACE OF MOTHER (City) (State or country) Southboro, Mass

21 Informant James R. Sherret
(Address) Southboro, Mass

A TRUE COPY
ATTEST: F. J. Gertrand
(Registrar of City or Town where death occurred)

DATE FILED July 9, 1951 19

Agent

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 26

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Southville Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Grace L. Bingham (Hodge) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Rd. St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 72 years ..... months 22 days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Sept. (Month) 17 (Day) 1951 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 31, 1951, to Sept 17, 1951

I last saw her alive on Sept. 17 1951, death is said to have occurred on the date stated above, at 11 to p. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma rt. lung c metastases to left lung.	1½ yrs.
ANTECEDENT CAUSES (b) Due To	
(c) Due To	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation..... Was autopsy performed? No.

What test confirmed diagnosis? Bronchoscopy - X-ray

5 Was disease or injury in any way related to occupation of deceased? No.

If so, specify.....

(Signed) H. J. Coulton, M. D.

(Address) Newton, Mass. Date 9/18 1951

6 Burial Southboro Mass (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL Sept. 20 1951

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS 620 W. Main St. Westboro Mass

Received and filed Sept. 22 1951

John J. Radene (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced
HUSBAND of..... (Give maiden name of wife in full)
(or) WIFE of Irving W. Bingham (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years ..... Months 22 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: straw worker (Kind of work done during most of working life)

14 Industry or Business: Hat Factory

15 Social Security No. 022-09-6883

16 BIRTHPLACE (City) Southboro (State or country) Mass

PARENTS

17 NAME OF FATHER Roswell Hodge

18 BIRTHPLACE OF FATHER (City) Vernon (State or country) New York

19 MAIDEN NAME OF MOTHER Mary Culver

20 BIRTHPLACE OF MOTHER (City) Compton (State or country) Vermont

21 Informant Irving W. Bingham (Address) Southville Rd. Southboro Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) 9/20/51 (Date of Issue of Permit)

50M (B)-12-49-900722

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 27

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alexander C. Gion (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Road St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 15 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 29, 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May, 1951, to Sept. 29, 1951

I last saw him alive on Sept. 29, 1951 death is said to have occurred on the date stated above, at 9:50 P. m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Coronary thrombosis	27 hrs.
ANTECEDENT CAUSES Due To (b)	Arteriosclerosis	2 yrs.
Due To (c)	Age and Diabetes (mellitus)	2 yrs.
OTHER SIGNIFICANT CONDITIONS	none	

Major findings: Of operations none

Date of operation none Was autopsy performed? no

What test confirmed diagnosis? Clincal

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Timothy P. Stone M. D.

(Address) Southboro Date 9/29/51 19

6 St. Patrick's Cem., Newport, N.H.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 3, 1951 19

7 NAME OF FUNERAL DIRECTOR John P. Rowe

ADDRESS 57 Main St., Marlboro

Received and filed October 9 19 51

John J. Rabbett
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced HUSBAND of Nellie Sweeney (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years Months Days | If under 24 hours Hours Minutes

13 Usual Occupation: Retired (Kind of work done during most of working life)

14 Industry or Business: Restaurant owner

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Dudley, mass.

PARENTS

17 NAME OF FATHER Gilbert Gion

18 BIRTHPLACE OF FATHER (City) (State or country) Canada

19 MAIDEN NAME OF MOTHER Mary Girard

20 BIRTHPLACE OF MOTHER (City) (State or country) Webster, Mass.

21 Informant (Address) Ovila Gion, Chandler St., Marlboro

A TRUE COPY
ATTEST: W. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED October 2, 1951 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 18

1 PLACE OF DEATH

Middlesex (County)

Framingham (City or Town)

No. Cushing VA Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Wilson Walker (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW I

(a) Residence. No. Turnpike Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 15 days. In place of residence life years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 15, 1951
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1951, to Oct. 15, 1951

I last saw him alive on Oct. 15, 1951, death is said to have occurred on the date stated above, at 12:45 p.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Pulmonary embolism	sudden
ANTECEDENT CAUSES Due To (b)	Phlebothrombosis, pelvic veins	4-5 days ?
Due To (c)	Post operative status after rt. pyelolithotomy	6 days
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations. Nephrolithiasis, rt.

Date of operation 10/9/51 Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Robert N. Cain, M.D. M. D.

(Address) Framingham, Mass. Date 10/15/51

6 Rural Cemetery - Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 18, 1951 19

7 NAME OF FUNERAL DIRECTOR Sumner Gage Funeral Home

ADDRESS 1521 Cotting St., Marlboro

Received and filed November 9 1951

John J. Rabeni
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced HUSBAND of Gladys Miller
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 53 Years 9 Months 12 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Power operator
(Kind of work done during most of working life)

14 Industry or Business: State of Mass.

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Northboro, Mass.

PARENTS

17 NAME OF FATHER Carl E. Walker

18 BIRTHPLACE OF FATHER (City) (State or country) Marlboro, Mass.

19 MAIDEN NAME OF MOTHER Mildred Power

20 BIRTHPLACE OF MOTHER (City) (State or country) Bucksport, Maine

21 Informant Hospital Records
(Address) Framingham, Mass.

A TRUE COPY
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED October 16, 1951 19

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 29

1 PLACE OF DEATH: (County) ..... (City or Town) Southboro. Mass.

No. Middle Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mrs. Lucy (Owen) Heckle
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) —

(a) Residence. No. Middles Road St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 15 years ..... months ..... days. In place of residence 15 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 30 1951
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1947, to Oct 30, 1951
I last saw her alive on Oct 18, 1951, death is said to have occurred on the date stated above, at 12:45 A. m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Coronary Thrombosis	sudden death.
ANTECEDENT CAUSES Due To (b)	Hypertensive Arteriosclerotic Heart Disease	5 yrs.
Due To (c)	Arteriosclerosis, general.	5 yrs.
OTHER SIGNIFICANT CONDITIONS	—	

Major findings: Of operations none
Date of operation none Was autopsy performed? no
What test confirmed diagnosis? clinical.

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Jimothy P. Stone, M. D.
(Address) Main St., Southboro Date 10-30 1951

MT. AUBURN Cemetery HOPKINTON, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOV. 2. 1951 19

7 NAME OF FUNERAL DIRECTOR J. L. Norton & Son John L. Norton & Son

ADDRESS Framingham, Mass.

Received and filed November 2 1951

John J. Baker
(Registrar)

50M (D)-6-50-902253

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	White	widowed.

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Hugh Heckle.
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years 10 Months 4 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: at home
(Kind of work done during most of working life)

14 Industry or Business: retired

15 Social Security No. .....

16 BIRTHPLACE (City) Liverpool
(State or country) England

PARENTS

17 NAME OF FATHER John Owen

18 BIRTHPLACE OF FATHER (City) Berry
(State or country) ######## England

19 MAIDEN NAME OF MOTHER Jane Armstrong

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) Ireland

21 Informant Miss. Mabel E. Hildreth HILDITCH
(Address) Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Jimothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Board of Health 10-30-51
(Official Designation) (Date of Issue of Permit)

Date of entering military service - March 30, 1917

Date of discharge - April 28, 1919

Rank, rating - Pvt.

Organization and outfit - 104 Inf.

Service number - 73521

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MMARLBOROUGH (City or town making return)

Registered No. 197 292

1 PLACE OF DEATH: MIDDLESEX (County); MARLBOROUGH (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John J. O'Neil (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Cross St. Southborough (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 6, 1951 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 8, 1951 19..., to Nov 6, 1951 19...

I last saw him alive on Nov 6, 1951, 19..., death is said to have occurred on the date stated above, at 3.25 A m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral hemorrhage	4½ Hrs
ANTECEDENT CAUSES Due To (b) Hypertension at least	3 Yr
Due To (c) Overweight -at least arteriosclerosis	3 Yr
OTHER SIGNIFICANT CONDITIONS Wt-266 Lb. Recent upper respiratory infection	3 dys

Major findings: Of operations none

Date of operation none Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? Possibly If so, specify Heavy pressure of work schedule

(Signed) Timothy P. Stone M. D.

(Address) Southboro Date Nov 6, 19 51

6 Rural Cemetery Southboro Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 8, 1951 19

7 NAME OF FUNERAL DIRECTOR John P. Rowe

ADDRESS Marlborough, Mass

Received and filed Dec. 13 19 51

John J. Baheni (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
M	W	Married

10a If married, widowed, or divorced HUSBAND of Della Foley (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 57 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Branch manager (Kind of work done during most of working life)

14 Industry or Business: Deerfoot Farms

15 Social Security No. 010-05-4897

16 BIRTHPLACE (City) (State or country) S. Boston, Mass

PARENTS

17 NAME OF FATHER John H. O'Neil

18 BIRTHPLACE OF FATHER (City) S. Boston, Mass (State or country)

19 MAIDEN NAME OF MOTHER Katherine Gray

20 BIRTHPLACE OF MOTHER (City) Boston, Mass (State or country)

21 Informant Mrs. John J. O'Neil (Address) Southboro

A TRUE COPY ATTEST: F. J. Bertrand (Registrar of City or Town where death occurred)

DATE FILED ..... 19.....

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 30

PLACE OF DEATH
1 Worcester (County)
Southboro (City or Town)
No. Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Nellie L. Howard
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Main St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV. 20, 1951
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from OCT. 1936 to Nov. 19, 1951

I last saw her alive on NOV. 19, 1951, death is said to have occurred on the date stated above, at 3:30 A. m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	CORONARY THROMBOSIS	1 Week
ANTECEDENT CAUSES Due To (b)	Arteriosclerosis	10 Years
Due To (c)	hypertension	15 Years
OTHER SIGNIFICANT CONDITIONS	senility	

Major findings:
Of operations.....
Date of operation..... Was autopsy performed?.....
What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify.....
(Signed) David P. Sher, M. D.
(Address) 176 Main St. Date 11/21, 1951

6 Rural Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL November 23 1951

7 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS 15-21 Cotting Ave., Marlboro

Received and filed Nov 24 1951
John J. Rabeni (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female | 9 COLOR OR RACE White | 10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 9 Months 1 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At home
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Southboro
(State or country) Mass.

PARENTS

17 NAME OF FATHER Isaac M. Howard

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER Ellen Belcher

20 BIRTHPLACE OF MOTHER (City) Winthrop
(State or country) Mass.

21 Informant Howard Newton
(Address) Wellesley Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent Bd of Health Nov 21, 1951
(Official Designation) (Date of Issue of Permit)

100M-(D)-10-48-24658

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12-49-900722

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 31

1 PLACE OF DEATH: Worcester (County) Middlesex; Southborough Marlboro (City or Town); No. ~~Marlboro Hosp.~~ Highview Hosp. Fayville Mass St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Frances V. Geary (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. 18 Main St. Framingham St. Framingham (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ....years....months....½ days. In place of residence 4 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. (Month) 24 (Day) 1951 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Thrombosis

5 Accident, suicide, or homicide (specify).....

Date and hour of injury.....19....

Where did Injury occur?..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) Walter F. Mahoney, M. D.

(A dress) Westborough Mass Date Nov 24 1951

7 Edgell Grove Framingham
Place of Burial, or ~~Cremation~~. (City or Town)

DATE OF BURIAL Nov 27 1951

8 NAME OF FUNERAL DIRECTOR Edward F. Bagley

ADDRESS 122 Hollis St. Framingham

Received and filed December 10 1951

John J. Rabeni (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

11a If married, widowed, or divorced HUSBAND of Nellie Kvasek (Give maiden name of wife in full)

(or) WIFE of ~~Nellie Kvasek~~ — (~~Husband's name in full~~)

12 IF STILLBORN, enter that fact here. —

13 AGE 47 Years....Months....Days. If under 24 hours ....Hours....Minutes

14 Usual Occupation: Bus Driver (Kind of work done during most of working life)

15 Industry or Business: B-W Lines - Driver

16 Social Security No. 019-10-5942

17 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

18 NAME OF FATHER: Frank Geary

19 BIRTHPLACE OF FATHER (City) (State or country): Boston, Mass

20 MAIDEN NAME OF MOTHER: Unknown

21 BIRTHPLACE OF MOTHER (City) (State or country): Unknown

22 Informant (Address) Mrs. Nellie Geary 18 Main St, Framingham

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Charles C. Wade. (Signature of Agent of Board of Health or other)

Agent. (Official Designation) Nov. 26, 1951. (Date of Issue of Permit)

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 32

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. School St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary A. Underwood (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Prentice St (Usual place of abode) St. (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 46 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: 11 (Month) 25 (Day) 1951 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 4, 1937, to Nov 24, 1951. I last saw her alive on Nov 24, 1951, death is said to have occurred on the date stated above, at 10 30 a.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) Hypostatic Pneumonia.	3 days
ANTECEDENT CAUSES	(b) Due To Chronic Myocarditis	3 yr.
	Due To Hypertension	
	(c) Due To Arteriosclerosis.	
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?..... If so, specify.....

(Signed) J. F. Cunningham, M.D.

(Address) Brigham St. Hospital Boston Date Nov 26 1951

6 Evergreen Cemetery Place of Burial or Cremation — Woodville (City or Town)

DATE OF BURIAL Nov. 27 1951

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westboro, Mass.

Received and filed Nov 28 1951

John J. Rabbini (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	white	widowed

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Granville Underwood (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years 2 Months 27 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No.

16 BIRTHPLACE (City) Mt. Pleasant (State or country) Nova Scotia

PARENTS

17 NAME OF FATHER Michael LeGay

18 BIRTHPLACE OF FATHER (City) Cannot be learned (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Lucy Naugler

20 BIRTHPLACE OF MOTHER (City) Mt. Pleasantville (State or country) Nova Scotia

21 Informant Harry Moore (Address) Southville, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Shore (Signature of Agent of Board of Health or other)

Agent Bd of Health (Official Designation) 11-26-51 (Date of Issue of Permit)

50M (B)-12-49-900722

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12.49-900722

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 1

PLACE OF DEATH
1 Worcester (County)
Southborough (City or Town)
No. Newton St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR).....

2 FULL NAME Harry S Beard Spurr
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. Newton Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 52 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 23 1952
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary sclerosis

5 Accident, suicide, or homicide (specify).....

Date and hour of injury.....19.....

Where did Injury occur?.....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?.....
(Specify type of place)

Manner of Injury.....
(How did injury occur?)

Nature of Injury.....

While at work?..... Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Walter J Mahoney, M. D.

(Address) Westborough Mass Date Jan 23 1952

7 Burial Southboro
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL January 26 1952

8 NAME OF FUNERAL DIRECTOR Sumner G. Tripp

ADDRESS 15-21 Cottage St, Marlboro

Received and filed Jan 23 1952

John J. Rabeni
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	m

11a If married, widowed, or divorced
HUSBAND of Emma L. Beard
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE Dec. 9 75 Years 1 Months 14 Days | If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Attendant Deerfoot Farms
(Kind of work done during most of working life)

15 Industry or Business:.....

16 Social Security No. 024-03-3416A

17 BIRTHPLACE (City) Tobrook Mines
(State or country) Annapolis County

PARENTS

18 NAME OF FATHER George H. Spurr

19 BIRTHPLACE OF FATHER (City) Nova
(State or country) Scotia

20 MAIDEN NAME OF MOTHER Margaret Magee

21 BIRTHPLACE OF MOTHER (City) Nova
(State or country) Scotia

22 Informant Alton B Spurr
(Address) Newton St, Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Board of Health Jan 23 1952
(Official Designation) (Date of Issue of Permit)

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12-49-900722

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 2

1 PLACE OF DEATH
(County) Worcester
(City or Town) Southboro, Mass.
No. Middle Road. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert V. Vitale
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Middle Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years 9 months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. (Month) 1 (Day) 1952 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
accidental death by drowning
when fell through ice on lake
near Parkerville Rd., Southboro.

5 Accident, suicide, or homicide (specify) accidents
Date and hour of injury 1:45 PM Feb 1 19 1952
Where did Injury occur? Southboro, Mass (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? On field near farm. (Specify type of place)
Manner of Injury Drowning Fell through ice (How did injury occur?)
Nature of Injury Drowning
While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) S. Allen Green, M. D.
(Address) Grafton, Mass. Date Feb 1 1952

7 Burial Cemetery Southboro Mass
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL Feb. 4 1952

8 NAME OF FUNERAL DIRECTOR J. J. Fenton & Son
ADDRESS Framingham Mass.

Received and filed February 6, 1952
John J. Rabeni (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX male
10 COLOR OR RACE white
11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) single

11a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 5 Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

14 Usual Occupation: at home.
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No.

17 BIRTHPLACE (City) Worcester
(State or country) Mass.

PARENTS

18 NAME OF FATHER

19 BIRTHPLACE OF FATHER (City)
(State or country)

20 MAIDEN NAME OF MOTHER Rose Vitale

21 BIRTHPLACE OF MOTHER (City) Worcester Mass.
(State or country)

22 Informant Mrs. James A. Smith
(Address) Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Board of Health 2-2-52
(Official Designation) (Date of Issue of Permit)

FORM R-307

DATE

THE ITEMS CHECKED ARE OMITTED OR INCOMPLETE ON DEATH CERTIFICATE FILED. KINDLY SUPPLY MISSING INFORMATION, SIGN AND RETURN THIS FORM TO DIVISION OF VITAL STATISTICS, OFFICE OF STATE SECRETARY, STATE HOUSE, BOSTON.

10m-1-47-20246

ADDITIONAL INFORMATION FOR DEATH CERTIFICATE

1 PLACE OF DEATH
County Worcester State Registered No. 2
City or Town Southborough No. St. Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert V. Vitale
(If deceased is a married, widowed or divorced women, give also maiden name.)
(If U. S. War Veteran, specify WAR)

(a) Residence. No. Middle Road St.
(Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution years months days. In this community yrs. mos. days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation:

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City)
(State or country)

PARENTS

13 NAME OF FATHER

14 BIRTHPLACE OF FATHER (City)
(State or country)

15 MAIDEN NAME OF MOTHER Rose Vitale

16 BIRTHPLACE OF MOTHER (City)
(State or country)

17 Relation, if any
Informant ( )
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH February 1 1952
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
I last saw h alive on , 19 , death is said to have occurred on the date stated above, at m.

Immediate cause of death

Leave name & birthplace of
Due to father out entirely
because child is
Due to illegimate,
We have adjusted our
Other conditions records accordingly.
(Include pregnancy within 3 months of death)
Please do likewise with yours

Duration Important

Physician

Major findings:
Of operations Thank you
Date of
Of autopsy

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?

If so, specify
(Signed) , M. D.
(Address) Date 19

21
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL 19

22 NAME OF FUNERAL DIRECTOR
ADDRESS

Received and filed 19

(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

BOSTON
(City or town making return)

Registered No. 2048

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

No. The Children's Hospt. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Harper (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) 3

(a) Residence. No. Lyman St. Southboro Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 3 months 24 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 5/52 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 19 51 to March 5, 19 52

I last saw him alive on March 5 19 52 death is said to have occurred on the date stated above, at 1;55A m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Hydrocephalus congenital	Since Birth
ANTECEDENT CAUSES Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Malnutrition	Since Birth

Major findings: Of operations Cavum septum pellucidae

Date of operation 10-11-51 Was autopsy performed? Yes

What test confirmed diagnosis? 11-13-51

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) R H Clauss M. D.

(Address) 300 Longwood Ave. Date 3-5 19 52

6 St Patrick's Cem-Natick Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 6/52 19

7 NAME OF FUNERAL DIRECTOR A H Doherty

ADDRESS Natick Mass.

Received and filed March 13 19 52

John J. Baleni (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
M	W	Single

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE Years 7 Months Days | If under 24 hours Hours Minutes

13 Usual Occupation: ------ (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Cambridge Mass.

PARENTS

17 NAME OF FATHER John H Harper Jr.

18 BIRTHPLACE OF FATHER (City) (State or country) Natick Mass.

19 MAIDEN NAME OF MOTHER Lois A Hanchett

20 BIRTHPLACE OF MOTHER (City) (State or country) Natick Mass.

21 Informant (Address) John H Harper Jr. Father

A TRUE COPY ATTEST: Charles H. Mackie (Registrar of City or Town where death occurred)

DATE FILED March 7/52 19

FORM R-301

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 4

1 PLACE OF DEATH: Worcester (County) Southbora (City or Town) No. Turnpike Rd Fayville St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret Mc Carthy (Collary) (If deceased was married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Boston Rd Southbora St. ..... (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death 3 years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: MARCH (Month) 17 (Day) 1952 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May, 1949 to March 17, 1952

I last saw her alive on Mar. 17, 1952 death is said to have occurred on the date stated above, at 1020 p.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	CEREBRAL HEMORRHAGE	3 Mos.
ANTECEDENT CAUSES Due To (b)	ARTERIOSCLEROSIS	10 yrs.
Due To (c)	HYPERTENSION	10 yrs.
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations .....

Date of operation ..... Was autopsy performed? .....

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify .....

(Signed) Dana A Allen M. D.

(Address) 68 Main St Date 3/18/52 1952

6 Rural Southbora mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 20 1952

7 NAME OF FUNERAL DIRECTOR Wm M. Tighe

ADDRESS Marlboro Mass

Received and filed March 19 1952

John J. Doherty (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Married

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of James Mc Carthy (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: at Home (Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Ireland

PARENTS

17 NAME OF FATHER William J Collary

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Nellie Connelly

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Paul Mc Carthy Nephew
(Address) White Basely Rd Southbora

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P Stone
(Signature of Agent of Board of Health or other)

Agent Bd of Health March 18, 1952
(Official Designation) (Date of Issue of Permit)

50M (A)-12-49-900722

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12-49-900722

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 5

PLACE OF DEATH

1 (County) Worcester

(City or Town) Southboro

No. Oak Hill Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Goodnow
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Oak Hill Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 5 years 6 months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 18 1952
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary sclerosis

5 Accident, suicide, or homicide (specify).....

Date and hour of injury.....19.....

Where did Injury occur?.....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?.....
(Specify type of place)

Manner of Injury.....
(How did injury occur?)

Nature of Injury.....

While at work?..... Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Walter F Mahoney M. D.

(A dress) Westborough Mass Date 3-18 1952

7 Rocklawn Marlboro
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL March 22 1952

8 NAME OF FUNERAL DIRECTOR Gunner & Gage

ADDRESS 15-21 Lathing Ave Marlboro

Received and filed March 22 1952

John J. Baleni
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female

10 COLOR OR RACE White

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

11a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of George A Goodnow
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE Dec 19 70 Years.....Months 29 Days

If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business: At home

16 Social Security No.....

17 BIRTHPLACE (City) England
(State or country)

PARENTS

18 NAME OF FATHER Henry Ellis

19 BIRTHPLACE OF FATHER (City) England
(State or country)

20 MAIDEN NAME OF MOTHER Mary (NK)

21 BIRTHPLACE OF MOTHER (City) England
(State or country)

22 Informant Blanche A Fitch
(Address) 36 Walnut Ave, Marlboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P Shone
(Signature of Agent of Board of Health or other)

Agent Board of Health March 20, 1952
(Official Designation) (Date of Issue of Permit)

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(h)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. 6

1 PLACE OF DEATH: Middlesex (County) — Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Benjamin A. MacArthur
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Woodland Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 4 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 23, 1952
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Fracture of the skull

5 Accident, suicide, or homicide (specify)
Date and hour of injury 3/23/52 19
Where did Injury occur? Framingham, Mass.
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Public Highway
(Specify type of place)
Manner of Injury Automobile Collision
(How did injury occur?)
Nature of Injury Fracture of skull
While at work? no Was autopsy performed? view

6 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Michael F. Burke, M. D.
(Address) Natick, Mass. Date 3/23/52 19

7 Cambridge Cambridge, Mass.
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL March 26, 1952 19

8 NAME OF FUNERAL DIRECTOR Charles B. Watson
ADDRESS Cambridge, Mass.

Received and filed April 15 1952
Frances E. Raben
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

11a If married, widowed, or divorced
HUSBAND of Gertrude Andrew
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 51 Years 6 Months 15 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Accountant
(Kind of work done during most of working life)

15 Industry or Business: Hospital

16 Social Security No. 022 14 8860

17 BIRTHPLACE (City) (State or country) Cambridge, Mass.

PARENTS

18 NAME OF FATHER Benjamin MacArthur

19 BIRTHPLACE OF FATHER (City) (State or country) Cambridge, Mass.

20 MAIDEN NAME OF MOTHER Linda Fraser

21 BIRTHPLACE OF MOTHER (City) (State or country) Nova Scotia, Canada

22 Informant Mrs. Gertrude MacArthur
(Address) Southboro, Mass.

A TRUE COPY.
ATTEST: Frances E. Raben
(Registrar of City or Town where death occurred)

DATE FILED April 3, 1952 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. 7

1 PLACE OF DEATH

Middlesex
(County)

Framingham
(City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Helene S. MacNeill (St.Pierre)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Latisquama Rd. St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 3 days. In place of residence 16 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 26, 1952
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 16, 1951, to Mar. 26, 1952

I last saw her alive on Mar. 26, 1952 death is said to have occurred on the date stated above, at 1:50 PM.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Cerebral Thrombosis	3½ mos.
ANTECEDENT CAUSES Due To (b)	Cerebral Arteriosclerosis	yrs.
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Hypertension 210 / 110	1 yr. at least

Major findings:
Of operations.....
Date of operation..... Was autopsy performed? no
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) Timothy P. Stone M. D.
(Address) Southboro, Mass. Date 3/26/52 19

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 29, 1952 19

7 NAME OF FUNERAL DIRECTOR John P. Rowe
ADDRESS Marlboro, Mass.

Received and filed April 05 1952
John J. Rabeno
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Married

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Malcolm A. MacNeill
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 61 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Nurse
(Kind of work done during most of working life)

14 Industry or Business: Medfield State Hosp.

15 Social Security No. 028 22 8898

16 BIRTHPLACE (City) Quebec, Canada
(State or country)

PARENTS

17 NAME OF FATHER Germaine St.Pierre

18 BIRTHPLACE OF FATHER (City) Quebec, Canada
(State or country)

19 MAIDEN NAME OF MOTHER Josephine Cartier

20 BIRTHPLACE OF MOTHER (City) Quebec, Canada
(State or country)

21 Informant Roderick N. MacNeill
(Address) Latisquama Rd., Southboro

A TRUE COPY
ATTEST: Wm J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED Mar. 29, 1952 19

FORM R-301

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc., It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 8

PLACE OF DEATH
1 (County) Worcester
(City or Town) Southboro
No. Turnpike Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George Whitney Miller (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Turnpike Road Fayville St. ..... (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL (Month) 2, (Day) 1952 (Year)

4 I HEREBY CERTIFY, That I attended deceased from MAY, 1949, to APRIL 2, 1952

I last saw him alive on April 2, 1952 death is said to have occurred on the date stated above, at 3.10 P. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) CARCINOMA OF PROSTATE-METASTASES TO NECK & CHEST.	6 MOS.
ANTECEDENT CAUSES Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS SENILITY	

Major findings:
Of operations.....
Date of operation..... Was autopsy performed? No
What test confirmed diagnosis? BIOPSY

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify.....
(Signed) David P. Stone M. D.
(Address) 180 Main St. Date 4/3/52 19

6 Crystal Lake Gardner
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 4 1952

7 NAME OF FUNERAL DIRECTOR Gunnar L. Gage
ADDRESS 15-21 Cottina Ave, Marlboro

Received and filed April 10 1952
John J. Baker (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced
HUSBAND of Bertha Smith (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 4 Months 2 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Farmer & Contractor (Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No. None

16 BIRTHPLACE (City) Gardner (State or country) Mass.

PARENTS

17 NAME OF FATHER David W. Miller

18 BIRTHPLACE OF FATHER (City) Westminster (State or country) Mass.

19 MAIDEN NAME OF MOTHER Laura Davis

20 BIRTHPLACE OF MOTHER (City) Ashburnham (State or country) Mass.

21 Informant Mrs. Bertha Miller (Address) Turnpike Rd. Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Bd. of Health (Official Designation) April 3, 1952 (Date of Issue of Permit)

50M (A)-1-51 903586

FORM R-301A

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 9

1 PLACE OF DEATH
Worcester (County)
Southboro (City or Town)
No. Ward St., Melendy Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Patrick Henry Gormley
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 15 Wood St. Hopkinton
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years ... months ... days. In place of residence 10 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Apr. 6 1952 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from January 1952 to March 29, 1952
I last saw him alive on March 29 1952, death is said to have occurred on the date stated above, at 6³⁰ p.m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cancer of face & ear

ANTECEDENT CAUSES Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS arteriosclerosis senility

Major findings:
Of operations
Date of operation ... Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) David D. Shea M. D.
(Address) 86 Main St Date 19

6 St. Mary's Cemetery, Milford
Place of Burial or Cremation (City or Town)
DATE OF BURIAL 4/9/1952

7 NAME OF FUNERAL DIRECTOR Seymour Wood
ADDRESS 15 Church St Hopkinton, Mass

Received and filed April 10 1952
John J. Rabein (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male
9 COLOR OR RACE White
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced HUSBAND of Nellie Bremmam
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years ... Months ... Days. If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Inspector of Shoes
(Kind of work done during most of working life)

14 Industry or Business: Shoe Shop

15 Social Security No.

16 BIRTHPLACE (City) Medway (State or country) Mass

PARENTS
17 NAME OF FATHER James Gormley
18 BIRTHPLACE OF FATHER (City) (State or country) Unknown
19 MAIDEN NAME OF MOTHER Unknown
20 BIRTHPLACE OF MOTHER (City) (State or country) Unknown

21 Informant Nellie MacDonald
(Address) 15 Wood St. Hopkinton

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Bd of Health (Official Designation)
April 8, 1952 (Date of Issue of Permit)

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

50M (D)-6-50-902253

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 10

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Quinn (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Road St. (Cordaville) Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ..... years ..... months 11 days. In place of residence 45 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 27, 1952 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 15, 1952 to April 27, 1952

I last saw him alive on April 27, 1952 death is said to have occurred on the date stated above, at 5:40P. m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Benign Hypertrophy of Prostate

ANTECEDENT CAUSES (b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS Bronchopneumonia

Arteriosclerotic heart disease

Major findings: Of operations Benign hypertrophy of prostate

Date of operation 4/18/52 Was autopsy performed? no

What test confirmed diagnosis? Pathological exam.

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) William H. Holtham M. D.

(Address) Framingham, Mass Date 4/27 1952

6 Rural Cem., Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 30, 1952 19

7 NAME OF FUNERAL DIRECTOR Thomas F. Callanan

ADDRESS Hopkinton, Mass.

Received and filed May 1 1952

John J. Baker SOUTHBORO
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Widowed

10a If married, widowed, or divorced HUSBAND of Mary Loggie (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Millworker (Kind of work done during most of working life)

14 Industry or Business: Blanket Mill

15 Social Security No. None

16 BIRTHPLACE (City) Boston, Mass. (State or country)

PARENTS

17 NAME OF FATHER Andrew M. Quinn

18 BIRTHPLACE OF FATHER (City) Ireland (State or country)

19 MAIDEN NAME OF MOTHER Cannot be learned Ames

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant Annette Quinn
(Address) Cordaville, Mass

A TRUE COPY
ATTEST: W. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED April 28, 1952 19 ...BOR

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. 11

1 PLACE OF DEATH

Middlesex (County)

Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert Stephen Jursek
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Central St. Fayville, Mass.
(Usual place of abode)

Length of stay: In place of death 15hrs.13min. years months days. In place of residence years months days.
(If nonresident, give city or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 6, 1952
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 6, 19 52, to May 6, 19 52

I last saw him alive on May 6, 19 52 death is said to have occurred on the date stated above, at 5:25PM m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Prematurity

ANTECEDENT CAUSES Due To (b) Circumvalate Placenta

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations

Date of operation Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) John F. Burke, M. D.

(Address) Framingham, Mass. Date 5/8/52, 19

6 Edgell Grove Framingham, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 8, 1952 19

7 NAME OF FUNERAL DIRECTOR Cookson Funeral Home

ADDRESS Framingham, Mass.

Received and filed June 13 1952

John J. Rabeni
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE Years Months Days — If under 24 hours 15 Hours 13 Minutes

13 Usual Occupation: (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Framingham, Mass. (State or country)

PARENTS

17 NAME OF FATHER Lark Jursek

18 BIRTHPLACE OF FATHER (City) Waterbury, Conn. (State or country)

19 MAIDEN NAME OF MOTHER Ruth Jepson

20 BIRTHPLACE OF MOTHER (City) Lincoln, Kansas (State or country)

21 Informant Lark Jursek
(Address) Central St., Fayville, Mass.

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED May 8, 1952 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

WORCESTER (City or town making return)

Registered No. 13

1 PLACE OF DEATH: WORCESTER (County); WORCESTER (City or Town)

No. St Vincent Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John T Neary (If deceased was married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Middle Road St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ..... years ..... months ..... 1 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 1, 1952 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 31 19 52 to June 1 19 52

I last saw h.. alive on June 1 19 52, death is said to have occurred on the date stated above, at 1m. 9:am

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Rupture of esophgeal varices — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES (b) Due To: Cirrhosis, Laennec's uncertain

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations

Date of operation ..... Was autopsy performed? no

What test confirmed diagnosis? clinical observation

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) John Meyers M. D.

(Address) Worcester Date 6-1- 19 52

6 Immaculate Conception Marlboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 4, 1952 19

7 NAME OF FUNERAL DIRECTOR John J Brown & Son

ADDRESS Marlboro

Received and filed July 8 19 52

John J. Rabeni
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 65 Years ... Months ... Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Dentist (Kind of work done during most of working life)

14 Industry or Business: Private practise

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Southboro

PARENTS

17 NAME OF FATHER John F Neary

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Delia Moran

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant (Address) Miss Margaret Neary Southboro

A TRUE COPY
ATTEST: Malcolm E. Midgley
(Registrar of City or Town where death occurred)

Russell T. Abel Asst.

DATE FILED June 4, 1952 19

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 12

PLACE OF DEATH
1 (County) Worcester
(City or Town) Southboro
No. Fatiguamma Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James E. O'Leary
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Fatiguamma Rd. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 12 years ..... months ..... days. In place of residence 74 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH (Month) June (Day) 3 (Year) 1952

4 I HEREBY CERTIFY, That I attended deceased from June 2, 1940, to June 3, 1952
I last saw him alive on June 2, 1952 death is said to have occurred on the date stated above, at 8:00 A m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) Hypertensive Heart Disease & Pt vent. failure	2 mos
ANTECEDENT CAUSES	Due To (b) hypertension	12 yrs+
	Due To (c)	
OTHER SIGNIFICANT CONDITIONS	Ca of Prostate	2 yrs+

Major findings:
Of operations.....
Date of operation..... Was autopsy performed? no
What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) Hugh LaCamera, M. D.
(Address) Framingham Date June 3 1952

6 Rural Cem. Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 6 1952

7 NAME OF FUNERAL DIRECTOR Samuel C. Gage
ADDRESS 5-21 Cottage Ave Marlboro

Received and filed June 5 1952
John J. Pallen
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced
HUSBAND of Bertha M. Priest
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years 10 Months 23 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired Superintendent
(Kind of work done during most of working life)

14 Industry or Business: Deerfoot Dairy

15 Social Security No.....

16 BIRTHPLACE (City) (State or country) White Head Kings County N. S.

PARENTS

17 NAME OF FATHER James Otis O'Leary

18 BIRTHPLACE OF FATHER (City) White Rock
(State or country) Kings Co. N. S.

19 MAIDEN NAME OF MOTHER Amy A. Cogburn

20 BIRTHPLACE OF MOTHER (City) New Rock Lunenburg
(State or country) Nova Scotia

21 Informant Bertha M. O'Leary
(Address) Fatiguamma Rd. Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Board of Health June 3, 1952
(Official Designation) (Date of Issue of Permit)

50M-(D)-6-51-904917

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

WORCESTER (City or town making return)

Registered No. 14

1 PLACE OF DEATH: WORCESTER (County) — WORCESTER (City or Town)

No. Memorial Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lillian F (Pearson) Smith (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. --- St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 26 days. 18 hrs 45 min In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 10, 1952 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 14, 19 52, to June 10 19 52

I last saw her alive on June 10, 19 52, death is said to have occurred on the date stated above, at 4:a m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) Cancer of mediastinum with metastases to liver, peritoneum and retroperitoneum	6 mos
ANTECEDENT CAUSES (b) Due To	
(c) Due To	
OTHER SIGNIFICANT CONDITIONS Hydrothorax	?

Major findings: Of operations --- Date of operation --- Was autopsy performed? yes

What test confirmed diagnosis? tissue from thoracentheses and chest plate

5 Was disease or injury in any way related to occupation of deceased? no If so, specify.....

(Signed) Salvador Ferandes M.D.

(Address) Worcester Date 6-10- 1952

6 Rural Cemetery, Southboro Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 12, 1952 19....

7 NAME OF FUNERAL DIRECTOR Geo Sessions for George Sessions Sons C

ADDRESS Worcester

Received and filed July 16 1952

John J. Baleni (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
female	white	married

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of William Smith (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 63 Years 3 Months 8 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) England

PARENTS

17 NAME OF FATHER George C Pearson

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER Caroline Field

20 BIRTHPLACE OF MOTHER (City) (State or country) England

21 Informant William Smith (Address) Southboro

A TRUE COPY ATTEST: Malcolm E Midgley (Registrar of City or Town where death occurred)

Russell F. Cook Asst.

DATE FILED June 11, 1952 19....

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

BOSTON

(City or town making return)

Registered No. 5951 (15)

1 PLACE OF DEATH: SUFFOLK / BOSTON (County) ..... (City or Town)

No. St. Elizabeth's Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME DAVID BERTRAND
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Main Street, (Usual place of abode) Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months....2....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 30, (Day) 1952 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6/29, 1952, to 6/30, 1952

I last saw him alive on 6/30, 1952, death is said to have occurred on the date stated above, at 12:55p. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) cardiac arrest	1 hr.
ANTECEDENT CAUSES (b) Due To	
(c) Due To	
OTHER SIGNIFICANT CONDITIONS Cleft Palate	2yrs.

Major findings: Of operations Cleft Palate, cardiac arrest

Date of operation 6/30/52 Was autopsy performed? No

What test confirmed diagnosis? Operation

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) B N Gilchrest, M. D.

(Address) St. Eliz. Hosp. Date 6/30 1952

6 Immaculate Conception Cem. Marlboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 3, 1952

7 NAME OF FUNERAL DIRECTOR J Rowe

ADDRESS Marlboro, Mass.

Received and filed July 12 1952

John J. Rabeni
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	W	Single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 2 Years 5 Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: - - -
(Kind of work done during most of working life)

14 Industry or Business: - - -

15 Social Security No. - - -

16 BIRTHPLACE (City) Marlboro, (State or country) Mass.

PARENTS

17 NAME OF FATHER Paul Bertrand

18 BIRTHPLACE OF FATHER (City) New Bedford, (State or country) Mass.

19 MAIDEN NAME OF MOTHER Lorraine Sheehan

20 BIRTHPLACE OF MOTHER (City) Marlboro, (State or country) Mass.

21 Informant P Bertrand
(Address)

A TRUE COPY Charles A. Mackie
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED July 2, 1952

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12-49-900722

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 16

1 PLACE OF DEATH: Worcester (County); Southborough (City or Town); No. Park St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Leonello F Lotti (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Park St. Southborough Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 2 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Aug (Month) 14 (Day) 1952 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

5 Accident, suicide, or homicide (specify).....

Date and hour of injury.....19.....

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Mass Date Aug 14 1952

7 Rural Cemetery, Southboro (Place of Burial, or Cremation.) (City or Town)

DATE OF BURIAL Aug 16, 1952

8 NAME OF FUNERAL DIRECTOR John A Coss

ADDRESS Marlboro Mass

Received and filed August 15 1952

John J. Rabeni (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

11a If married, widowed, or divorced HUSBAND of Marie Cecchetti (Give maiden name of wife in full)

(or) WIFE of..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 67 Years.....Months.....Days. If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Retired - Janitor (Kind of work done during most of working life)

15 Industry or Business: Business Block

16 Social Security No. 032-20-8361

17 BIRTHPLACE (City) (State or country) Ausblainke Italy

PARENTS

18 NAME OF FATHER Charles Lotti

19 BIRTHPLACE OF FATHER (City) (State or country) Unobtainable Italy

20 MAIDEN NAME OF MOTHER Carmen Mattioli

21 BIRTHPLACE OF MOTHER (City) (State or country) Unobtainable Italy

22 Informant Mrs Joseph McIntyre (Address) Park St Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) August 15, '52 (Date of Issue of Permit)

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 17

PLACE OF DEATH
1 Worcester (County)
Southboro (City or Town)
No. Winter St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ida Florence Gray
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Winter St. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 25 years....months....days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc., It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 31 1952
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1952 to Aug 31, 1952
I last saw h.e alive on Aug 30, 1952 death is said to have occurred on the date stated above, at 6 57 9 a.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral thrombosis	24 hr.
ANTECEDENT CAUSES Due To (b) arteriosclerosis	10 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Hypertension	

Major findings:
Of operations
Date of operation Was autopsy performed? no
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) John Paul Cream M.D.
(Address) Turnpike St. Date 8/31 1952

6 Burial
Place of Burial or Cremation Southboro (City or Town)
DATE OF BURIAL Sept 1 1952

7 NAME OF FUNERAL DIRECTOR Sammons & Gage
ADDRESS 15-21 Cutting Ave. Marlboro

Received and filed Sept. 9 1952
John J. Rabeni
(Registrar)
A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR OR RACE White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced
HUSBAND of John Grant Gray
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 Years 11 Months 26 Days
If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Charlestown
(State or country) Mass.

PARENTS

17 NAME OF FATHER Stephen C. Currier

18 BIRTHPLACE OF FATHER (City) North Andover
(State or country) New Hampshire

19 MAIDEN NAME OF MOTHER Elizabeth C Chase

20 BIRTHPLACE OF MOTHER (City)
(State or country) New Hampshire

21 Informant Mrs. Mariella Charles Mauro
(Address) Winter St.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Bd. of Health
(Official Designation) (Date of Issue of Permit) 8/31/52

50M (A)-1-51 903586

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 18

1 PLACE OF DEATH: Middlesex (County) — Southboro (City or Town) — No. Pinkerville Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles Arthur Le Hay
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. Pinkerville Rd St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 37 years ..... months ..... days. In place of residence ..... years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 9/10/52 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1952, to Sept 9, 1952
I last saw him alive on Sept 9, 1952, death is said to have occurred on the date stated above, at 12:56 A.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral Hemorrhage	13 days
ANTECEDENT CAUSES Due To (b) Arteriosclerosis with Hypertension	at least 4 yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Past History of Coronary Thrombosis	26 months

Major findings: Of operations —
Date of operation — Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify —
(Signed) Timothy P. Stone, M. D.
(Address) Southboro, Mass. Date 9/10 1952

6 Rural Cemetery Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL 9/12/52 19

7 NAME OF FUNERAL DIRECTOR Seymour A. Wood
ADDRESS 15 Church St. Hopkinton

Received and filed Sept 16 1952
Hames E Roberts
(Registrar)
asst

50M (D)-6-50-902253

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced HUSBAND of Florence Lincoln
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 74 Years 3 Months 0 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Carpenter
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 021-05-0754

16 BIRTHPLACE (City) Mt. Pleasant
(State or country) Nova Scotia

PARENTS

17 NAME OF FATHER — Le Hay

18 BIRTHPLACE OF FATHER (City)
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER — Hogler

20 BIRTHPLACE OF MOTHER (City)
(State or country) Nova Scotia

21 Informant Florence L. Le Hay
(Address) Pinkerville Rd.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent Board of Health Sept 11, 1952
(Official Designation) (Date of Issue of Permit)

FORM R-301

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 17

PLACE OF DEATH
1 (County) Worcester
(City or Town) Southboro
No. School St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Barbara Birss Dempsey
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. School St St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 15 years.....months.....days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc., It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. (Month) 22 (Day) 1952 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 29, 1952, to Sept. 22, 1952

I last saw her alive on Sept. 22, 1952, death is said to have occurred on the date stated above, at 5:55 P.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) Carcinoma of Cecum	5 mos.
ANTECEDENT CAUSES	Due To (b)	
	Due To (c)	
OTHER SIGNIFICANT CONDITIONS	Chronic Myocarditis	1 yr.

Major findings: Of operations.....

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) R. E. Johnson M. D.
(Address) Marlboro, Mass. Date 9/22 1952

6 Mount Hope Cemetery Boston
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Sept. 24, 1952 19

7 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS 15-21 Lotting Ave., Marlboro

Received and filed Sept. 22 1952
John J. Baleni (Registrar)
A TRUE COPY ATTEST

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of.....
(or) WIFE of Earnest Wm. Dempsey (Give maiden name of wife in full) (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years 10 Months 7 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No.....

16 BIRTHPLACE (City) (State or country) Eton England

PARENTS

17 NAME OF FATHER James Birss BIRSS

18 BIRTHPLACE OF FATHER (City) Eton (State or country) England

19 MAIDEN NAME OF MOTHER Mary Sim

20 BIRTHPLACE OF MOTHER (City) Aberdeen (State or country) Scotland

21 Informant Mrs. Frederick L. Laflin
(Address) School St., Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Board of Health 9/23/52
(Official Designation) (Date of Issue of Permit)

50M (A)-1-51 903566

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 28

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Boy Ansell (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Woodland Rd. St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 6, 1952. (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 10/6/52, 19....., to 10/6/52, 19.....

I last saw ~~him~~ alive on STILLBORN, 19....., death is said to have occurred on the date stated above, at 8:40 p. m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Abortion

ANTECEDENT CAUSES Due To (b) Premature separation of the Placenta and Hemorrhage — 21 dys.

Due To (c)

OTHER SIGNIFICANT CONDITIONS none

Major findings: Of operations none

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Timothy P. Stone, M. D.

(Address) Southboro, Mass. Date 10/7/ 19 52

6 Edgell Grove Cem. Framingham
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 8, 1952. 19

7 NAME OF FUNERAL DIRECTOR Cookson Funeral Home

ADDRESS Framingham, Mass.

Received and filed Oct. 9 19 52

John J. Fabeni SOUTHBORO
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	single

10a If married, widowed, or divorced
HUSBAND of..... (Give maiden name of wife in full)

(or) WIFE of..... (Husband's name in full)

11 IF STILLBORN, enter that fact here. STILLBORN

12 AGE.....Years.....Months.....Days If under 24 hours .....Hours.....Minutes

13 Usual Occupation:..... (Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) (State or country) Framingham, Mass.

PARENTS

17 NAME OF FATHER Clifford Ansell

18 BIRTHPLACE OF FATHER (City) (State or country) Owensdale, Pa.

19 MAIDEN NAME OF MOTHER Juanita Gross

20 BIRTHPLACE OF MOTHER (City) (State or country) Quincy, Illinois

21 Informant Clifford Ansell
(Address) Southboro, Mass.

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED October 8, 1952. 19

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 21

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town)

No. East Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Arlene B. Maccioli (Hinckley)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. East Main St. St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 4 years.....months.....days. In place of residence.....years.....months.....days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc., It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 15, (Day) 1952 (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 4 1952 to October 15, 1952

I last saw h.er alive on October 15, 1952, death is said to have occurred on the date stated above, at 9:30 p.m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Rheumatic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH about 20 years

ANTECEDENT CAUSES Due To (b) .....

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS .....

Major findings: Of operations.....

Date of operation.....Was autopsy performed? no

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....

(Signed) Albert E. Schwartz M. D.
(Address) Marlboro Mass Date Oct. 16 1952

6 Rural Cemetery Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 18, 1952

7 NAME OF FUNERAL DIRECTOR John J. Brown & Son

ADDRESS 95 West Main St. Marlboro

Received and filed October 17 1952

John J. Fabeni
(Registrar)

A TRUE COPY ATTEST:

50M (A)-1-51 903586

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Frank Maccioli
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 30 Years 1 Months 13 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. 028-16-5208

16 BIRTHPLACE (City) Marlboro
(State or country) Mass

PARENTS

17 NAME OF FATHER William Hinckley

18 BIRTHPLACE OF FATHER (City) Marlboro
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Marion Benway

20 BIRTHPLACE OF MOTHER (City) Hudson
(State or country) Mass.

21 Informant Mr. Frank J. Maccioli
(Address) East Main St. Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) OCT 17 1952 (Date of Issue of Permit)

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (6)-8-50-902 592

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 93

PLACE OF DEATH

1 Worcester (County)
Southboro (City or Town)

No. Boston-Worcester Turnpike St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Albert Blanta
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 20 Alfred St. Springfield Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death — years 2 months — days. In place of residence — years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct 18 1952
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fract Skull and fractured Cervical Spine

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury Oct 18 1952

Where did Injury occur? Southborough Mass
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Highway
(Specify type of place)

Manner of Injury Hit by automobile
(How did injury occur?)

Nature of Injury Fract Skull and Cervical Spine

While at work? yes Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? yes

If so, specify Driving truck fills with lumber

(Signed) Walter F Mahoney M. D.

(Address) Westborough Mass Date Oct 19 1952

7 St Michaels Shrine Southborough Mass
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Oct 21 1952

8 NAME OF FUNERAL DIRECTOR George St Pierre & Son

ADDRESS Springfield Mass

Received and filed Oct 21 1952

John J Palmieri
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

11a If married, widowed, or divorced HUSBAND of Irene Duquette
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 51 Years Months Days | If under 24 hours Hours Minutes

14 Usual Occupation: Lumber Business
(Kind of work done during most of working life)

15 Industry or Business: Self Employed

16 Social Security No. 001-01-5291

17 BIRTHPLACE (City) Cannot be learned
(State or country) Canada

PARENTS

18 NAME OF FATHER Ludger Blanta

19 BIRTHPLACE OF FATHER (City) Cannot be learned
(State or country) Canada

20 MAIDEN NAME OF MOTHER Claudia Brocker

21 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country) Canada

22 Informant Mrs Jean Bernault
(Address) 20 Alfred St Springfield Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P Shore
(Signature of Agent of Board of Health or other)

Agent Bd of Health
(Official Designation)

OCT 19 1952
(Date of Issue of Permit)

FORM R-303

MARGIN RESERVED FOR BINDING

N. B. —WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (C)-12-49-900722

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or town making return)

Registered No. 33

1 PLACE OF DEATH: Worcester (County) Southboro (City or Town)

No. Framingham Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Gordon A. Kenison (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) World War II

(a) Residence. No. Learned St., Fayville St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 2 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 20 1952 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fract. Skull

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury Oct 20 1952

Where did Injury occur? Southborough Mass (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Highway (Specify type of place)

Manner of Injury Auto accident (How did injury occur?)

Nature of Injury Fract Skull

While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Walter F. Mahoney, M. D.

(Address) Date 19

7 Mt Feake Waltham Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL October 24 23 1952

8 NAME OF FUNERAL DIRECTOR William P. Miller

ADDRESS 27 Spruce St. Waltham Per A.L. Gage

Received and filed Oct 22 1952 SOUTHBORO

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male

10 COLOR OR RACE: White

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

11a If married, widowed, or divorced
HUSBAND of Dorothy Ann Mahoney (Give maiden name of wife in full)
(or) WIFE of Dorothy Gordon A. Kenison (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 28 Years 6 Months 18 Days | If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Machinist (Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. 030-18-5645

17 BIRTHPLACE (City) Arlington (State or country) Mass

PARENTS

18 NAME OF FATHER Harry Kenison

19 BIRTHPLACE OF FATHER (City) Massachusetts (State or country)

20 MAIDEN NAME OF MOTHER Mary Perigo

21 BIRTHPLACE OF MOTHER (City) Massachusetts (State or country)

22 Informant Dorothy Ann Mahoney (Address) Learned St., Fayville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) OCT 21 1952 (Date of Issue of Permit)

EXTRACTS
FROM THE LAWS OF THE
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L. as amended by Chap. 48, Acts of 1927 and Chap. 414, Acts of 1931.

No undertaker or other person shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.....Chap. 114, Sec. 46, G. L., as amended.

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead.....— General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

.....The medical examiner certifies the cause and manner of death to the best of his knowledge and belief.

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a steam railway accident." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1)Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE November 2, 1942

DATE OF DISCHARGE Dec. 24, 1945

RANK, RATING Cpl.

ORGANIZATION AND OUTFIT ~~11115385 Cpl~~, 1342 A.T.C.

SERVICE NUMBER 11115385

FORM R-303

MARGIN RESERVED FOR BINDING

N. B. —WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (C)-12-49-900722

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or town making return)

Registered No. 74

PLACE OF DEATH

1 Worcester (County)
Southboro (City or Town)
No. Framingham Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ernest R. Oulton
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) World War II

(a) Residence. No. 28 Phelps St. Marlborough Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 4 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 24 1952
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fract Skull

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury Oct 20 1952
Where did Injury occur? Southborough Mass
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Highway
(Specify type of place)
Manner of Injury Auto accident
(How did injury occur?)
Nature of Injury Fract Skull
While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Walter F. Mahoney, M. D.
(Address) Westborough Date Oct 24 1952

7 Riverside Cemetery (City or Town)
Place of Burial, or Cremation.
DATE OF BURIAL Oct. 23 1952

8 NAME OF FUNERAL DIRECTOR Summerhays & Grace
ADDRESS 15-21 Cottage Ave., Marlboro

Received and filed Oct 22 1952
John J. Cahenne (Registrar)
A TRUE COPY ATTEST: SOUTHBORO

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male
10 COLOR OR RACE White
11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Divorced

11a If married, widowed, or divorced
HUSBAND of Arline Saunders
(Give maiden name of wife in full)
(or) WIFE of Ernest R. Oulton
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 27 Years 11 Months 22 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Mechanic
(Kind of work done during most of working life)

15 Industry or Business: a

16 Social Security No. 029-14-2194

17 BIRTHPLACE (City) Swampscott Mass.
(State or country)

PARENTS

18 NAME OF FATHER George H. Oulton

19 BIRTHPLACE OF FATHER (City) Port Elgin N. B. Canada
(State or country)

20 MAIDEN NAME OF MOTHER Ethel M. Carter

21 BIRTHPLACE OF MOTHER (City) Lynn Mass.
(State or country)

22 Informant George M. Oulton
(Address) 28 Phelps St.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent Board of Health OCT 21 1952
(Official Designation) (Date of Issue of Permit)

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L. as amended by Chap. 48, Acts of 1927 and Chap. 414, Acts of 1931.

No undertaker or other person shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.........Chap. 114, Sec. 46, G. L., as amended.

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead.......— General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

......The medical examiner certifies the cause and manner of death to the best of his knowledge and belief.

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a steam railway accident." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1)Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE Feb 8 1943

DATE OF DISCHARGE April 15 1946

RANK, RATING Private

ORGANIZATION AND OUTFIT Air Force Ground Crew

SERVICE NUMBER 31295960

RHODE ISLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL STATISTICS

CORRECTION OF DEATH CERTIFICATE

Date of Oct 29, 1952 SUSANNE STANTON WOOD

Name of TO BE CORRECTED TO SUSANNE STANTON WOOD

Father's Name AS INFORMANT'S MRS EDITH C. ADAMS AND NOT

Mother's Name AS MRS EDITH C. ADAMS.

Burial Place ELM GROVE CEMETARY - ALLENTON INFORMANT

Miscellaneous AND NOT WICKFORD UNDERTAKER - WALTER F MAHONEY WEST BORO, MASS AND GEORGE C. CRANSTON, EST. WICKFORD R.I.

Source of information from which addition or correction has been made:

MRS EDITH C. ADAMS SHERMAN R.I.

Date of correction May 14, 1953

Harold L Carey

[SEAL]

PLEASE FURNISH US A CORRECTED COPY

Local Registrar
TOWN OF NORTH KINGSTOWN
WICKFORD
R.I.

V. S. 104-16M-11-51 ELF 1900

TOWN CLERK OF NORTH KINGSTOWN

HAROLD L. COREY

TOWN CLERK OF NORTH KINGSTOWN
WICKFORD, R. I.

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12-49-900722

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 25

1 PLACE OF DEATH
Worcester (County)
Southborough (City or Town)
No. Main St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Susanne Stanton Wood
(If deceased was a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Ely School St. Southborough Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 3 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct (Month) 27 (Day) 1952 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary Sclerosis

5 Accident, suicide, or homicide (specify)....

Date and hour of injury....19....

Where did Injury occur?....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?....
(Specify type of place)

Manner of Injury....
(How did injury occur?)

Nature of Injury....

While at work?.... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify....

(Signed) Walter S Mahoney, M. D.

(A dress) Westborough Mass Date Oct 27 1952

7 Place of Burial, or Cremation. Glen Grove Richford R.I.
(City or Town)

DATE OF BURIAL Oct 30 CRANSTON 1952

8 NAME OF FUNERAL DIRECTOR Grace C. Chamberlain

ADDRESS 140 Westminster St Providence R.I.

Received and filed October 29 1952

John J. Rabbitt
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female

10 COLOR OR RACE White

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Single

11a If married, widowed, or divorced
HUSBAND of....
(Give maiden name of wife in full)

(or) WIFE of....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 59 Years 9 Months 10 Days | If under 24 hours ....Hours....Minutes

14 Usual Occupation: Dietitian
(Kind of work done during most of working life)

15 Industry or Business:....

16 Social Security No. 242-36-6166

17 BIRTHPLACE (City) (State or country) North Kingstown R.I.

PARENTS

18 NAME OF FATHER Arthur Wood

19 BIRTHPLACE OF FATHER (City) Providence (State or country) R.I.

20 MAIDEN NAME OF MOTHER Mary A. Moore

21 BIRTHPLACE OF MOTHER (City) Richmond (State or country) R.I.

22 Informant Mrs. Edith G. Adams
(Address) Glocum R.I.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Bd. of Health
(Official Designation) (Date of Issue of Permit) 10-28-52.

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 26

PLACE OF DEATH
1 Worcester (County)
Southboro (City or Town)

No. Cordaville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Vermina C. Baldelli nee Serfilippi (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Cordaville Road St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death 39 years ..... months ..... days. In place of residence 39 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 31 (Day) 1952 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1952, to Oct. 31, 1952

I last saw her alive on Oct 30, 1952, death is said to have occurred on the date stated above, at 4.58 A. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma of Lung	1951
ANTECEDENT CAUSES Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis? X Ray

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Albert E. Le Lacheur M. D.

(Address) Marlboro Date Nov. 1 1952

6 Rural Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 3 1952

7 NAME OF FUNERAL DIRECTOR T. F. Calahan & Son

ADDRESS Hopkinton Mass.

Received and filed Nov 4 1952

John J. Rabini
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Married

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Eugene Baldelli
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 59 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Bergamo
(State or country) Italy

PARENTS

17 NAME OF FATHER Guiseppi Serfilippi

18 BIRTHPLACE OF FATHER (City).....
(State or country) Italy

19 MAIDEN NAME OF MOTHER Antonia —

20 BIRTHPLACE OF MOTHER (City).....
(State or country) Italy

21 Informant Eugene Baldelli
(Address) Southboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Board of Health
(Official Designation)

NOV 1 1952
(Date of Issue of Permit)

50M (D)-6-50-902253

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 27

1 PLACE OF DEATH: Worcester (County); Southville (City or Town)

No. Southville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME August Stucker (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Road St. Southville Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 6 months ..... days. In place of residence ..... years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Nov. (Month) 20. (Day) 1952 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 19 52, to Nov. 20, 19 52

I last saw h[e] alive on Nov 20, 19 52 death is said to have occurred on the date stated above, at 3[30] p. m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral Hem. — 17 days.

ANTECEDENT CAUSES Due To (b) Hem. Arteriosclerosis

Due To (c) Senility

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) [signature] M. D.

(Address) Webster, Mass Date 11/20 19 52

6 Hope Cemetery Worcester (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL November 22 1952 19

7 NAME OF FUNERAL DIRECTOR Geo Briggs for George Sessions Sons Co

ADDRESS 71 Pleasant St Worcester

Received and filed Nov 25 19 52

John J. Rabeni (Registrar)

50M (D)-6-50-902253

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed.

10a If married, widowed, or divorced HUSBAND of Anna O'Brien (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 5 Months 8 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Woolen Factory Manager (Kind of work done during most of working life)

14 Industry or Business: retired 30 years

15 Social Security No.....

16 BIRTHPLACE (City) Louisville (State or country) Kentucky

PARENTS

17 NAME OF FATHER Frank Stucker

18 BIRTHPLACE OF FATHER (City) Mayfield (State or country) Kentucky

19 MAIDEN NAME OF MOTHER Louise [illegible] can not be le

20 BIRTHPLACE OF MOTHER (City) Can not be learned. (State or country)

21 Informant (Address) Mrs. Florence M Stimson Southville Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) 11-22-52 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH
(City or town making return)

Registered No. 249 28

1 PLACE OF DEATH

MIDDLESEX (County)

MARLBOROUGH (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Infant Murphy
(If deceased was married, widowed, or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Park St St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH (Month) Dec 9, 1952 (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 9 19 52 to Dec 9, 19 52

I last saw h.....alive on....., 19....., death is said to have occurred on the date stated above, at.....m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Stillborn 6½ mos

ANTECEDENT CAUSES Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations.....

Date of operation.....Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....

(Signed) William J. Betinis M. D.
(Address) Marlborough, Mass 12-10-52

6 Placed (Burial or Cremation) Rural Cem (City or Town) Southboro Mass

DATE OF BURIAL Dec 10, 1952 19

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass

Received and filed Jan 10 1953

F. J. Bertrand
(Registrar of City or Town where deceased resided)

John J Raheem

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	W	Single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here. Stillborn

12 AGE.....Years.....Months.....Days If under 24 hours .....Hours.....Minutes

13 Usual Occupation:.....
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Marlborough, Mass
(State or country)

PARENTS

17 NAME OF FATHER Joseph K Murphy

18 BIRTHPLACE OF FATHER (City) Somerville, Mass
(State or country)

19 MAIDEN NAME OF MOTHER Julia Lotti

20 BIRTHPLACE OF MOTHER (City) Milford, Mass
(State or country)

21 Informant Joseph K. Murphy
(Address)

A TRUE COPY
ATTEST: F. J. Bertrand
(Registrar of City or Town where death occurred)

DATE FILED Dec 12, 1952 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Ashland (City or town making return)

Registered No. 29

1 PLACE OF DEATH: (County) Middlesex; (City or Town) Ashland; No. 7 Central St (If death occurred in a hospital or institution, give its NAME instead of street and number) (Mary Jane Rest Home) St.

2 FULL NAME Rose A. (Gilmore) Maroney (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. E. Main St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 8 months 18 days. In place of residence 2 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Dec (Month) 12 (Day) 1952 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 29 1952 to Dec 12, 1952

I last saw h[er] alive on Dec 11 1952, death is said to have occurred on the date stated above, at 10:40 A.m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) hypocardial insuff. (congestive failure) — INTERVAL BETWEEN ONSET AND DEATH: 5 da

ANTECEDENT CAUSES (b) Due To Generalized arteriosclerosis — over 1 yr

(c) Due To old age

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations None

Date of operation — Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Timothy P. Stone M. D.

(Address) Main St. Southboro Date 12-12 1952

6 St Mary's Cem. Milford
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec 15 1952

7 NAME OF FUNERAL DIRECTOR Joseph F. Edwards

ADDRESS 76 Central St. Milford

Received and filed Dec 12 1-3-53

John J. Rabeni
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female | 9 COLOR OR RACE: White | 10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): widowed

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Cornelius M. Maroney (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 92 Years Months 4 Days 12 | If under 24 hours Hours Minutes

13 Usual Occupation: at home (Kind of work done during most of working life)

14 Industry or Business: Home

15 Social Security No. not

16 BIRTHPLACE (City) (State or country) Natick Mass

PARENTS

17 NAME OF FATHER Alexander Gilmore

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Julia Finn

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Mrs Alice Bernardi
(Address) 78 West St. Milford

A TRUE COPY
ATTEST: J. Francis McGill
(Registrar of City or Town where death occurred)

DATE FILED Dec 12 1952

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH (City or town making return)

Registered No. 2

1 PLACE OF DEATH

MIDDLESEX (County)

MARLBOROUGH (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Nettie Delarda
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Cherry St. Fayville, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ... years ... months 21 days. In place of residence 20 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan 3, 1953
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 15, 1952, to Jan 3, 1953

I last saw her alive on Jan 3, 1953, death is said to have occurred on the date stated above, at 7.10 P.m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) Adeno-carcinoma of pancreas	1 yr
ANTECEDENT CAUSES Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations: adenocarcinoma of pancreas

Date of operation May 23, 1952 Was autopsy performed? no

What test confirmed diagnosis? Pathological

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) John J. Lepore, M. D.

(Address) Marlborough Date 1-5-53

6 Rural Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan 7, 1953

7 NAME OF FUNERAL DIRECTOR William M. Tighe

ADDRESS Marlborough

Received and filed F. J. Bergeron April 1, 53

John J. Rabeni
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	W	Single

10a If married, widowed, or divorced HUSBAND of
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 53 Years ... Months ... Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Shoeworker
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 017-05-5305

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Charles Delarda

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Louise Bosconi

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Angelo Delarda
(Address) Fayville

A TRUE COPY.

ATTEST:
(Registrar of City or Town where death occurred)

DATE FILED Jan 5, 1953

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(h)-10-48-24658

3

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John Berry (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Main St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death .....years .....months 10 mins. days. In place of residence .....years .....months .....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 20, 1953. (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Inteatinal obstruction from strangulation of right inguinal hernia #122

5 Accident, suicide, or homicide (specify) no

Date and hour of injury ..... 19.....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) J. H. McCann, M. D.

(Address) Framingham, Mass. Date 2/22 19 53

7 Rural Cemetery, Southboro, Mass. Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Feb. 23, 1953. 19.....

8 NAME OF FUNERAL DIRECTOR Cookson Fun. Home

ADDRESS Framingham, Mass.

Received and filed February 23 1953

John J. Baker (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: male

10 COLOR OR RACE: white

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): single

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 79 Years .....Months .....Days | If under 24 hours .....Hours .....Minutes

14 Usual Occupation: Cleaning & Pressing (Kind of work done during most of working life)

15 Industry or Business: Self-employed

16 Social Security No. .....

17 BIRTHPLACE (City) (State or country) England

PARENTS

18 NAME OF FATHER: C.N.B.L.

19 BIRTHPLACE OF FATHER (City) (State or country): C.N.B.L.

20 MAIDEN NAME OF MOTHER: C.N.B.L.

21 BIRTHPLACE OF MOTHER (City) (State or country): C.N.B.L.

22 Informant Rev. Harry E. Gall, Jr.
(Address) Southboro Mass.

A TRUE COPY.
ATTEST: W. A. Walsh
(Registrar of City or Town where death occurred)

DATE FILED Feb. 25, 1953. 19.....

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50m-(g)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Easterly Farms- St. Pine Hill Rd. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME James William O'Brien (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 67 Winthrop St St. Cambridge Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 6 months 7 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: February 22 1953 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

asphyxiation - orange juice regurgitated into trachea

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury Feb 22 1953

Where did Injury occur? Southborough Mass (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Farm (Specify type of place)

Manner of Injury Regurgited food into trachea (How did injury occur?)

Nature of Injury asphyxiation

While at work? Yes Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Nelan F Mahoney, M. D.

(Address) Westborough Mass Date 2-22 1953

7 ~~Holy~~ St Joseph's W. Roxbury (Place of Burial, or Cremation) (City or Town)

DATE OF BURIAL Feb 24 1953

8 NAME OF FUNERAL DIRECTOR Francis J. Mahoney

ADDRESS 333 Harvard Ave Cambridge

Received and filed February 25 1953

John J. Rabens (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE Years 6 Months 7 Days — If under 24 hours: Hours ..... Minutes

14 Usual Occupation: none (Kind of work done during most of working life)

15 Industry or Business: none

16 Social Security No. none

17 BIRTHPLACE (City) (State or country): Cambridge Mass

PARENTS

18 NAME OF FATHER: Henry J. O'Brien

19 BIRTHPLACE OF FATHER (City) (State or country): Cambridge Mass

20 MAIDEN NAME OF MOTHER: Marion C. Tyrrell

21 BIRTHPLACE OF MOTHER (City) (State or country): Brocton Mass.

22 Informant Henry J. O'Brien Father (Address) 65 Winthrop St Cant.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent Board of Health 2 24 53 (Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

4

1 PLACE OF DEATH: Worcester (County) — Westborough (City or Town)

Westborough (City or town making return)

Registered No. 52

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Howard P. Wheeler (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Prentiss (Usual place of abode) St. Southville, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death 3 years 4 months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 10, 1953 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1952 to Mar. 10, 1953

I last saw him alive on Mar. 10, 1953, death is said to have occurred on the date stated above, at 6:30 p. m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Myocardial Degeneration

ANTECEDENT CAUSES Due To (b) Generalized Arteriosclerosis

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations

Date of operation None Was autopsy performed? No

What test confirmed diagnosis? Clinical Findings

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Diana L. Rodriguez M. D.

(Address) Westboro State Hosp. Date Mar. 10 1953

6 Rural, Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 13, 1953

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westboro, Mass.

Received and filed April 17 1953

John L. Palen

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced HUSBAND of Ethel (cannot be learned (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 Years 1 Months 9 Days — If under 24 hours Hours Minutes

13 Usual Occupation: Retired Laborer (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Mason (State or country) Michigan

PARENTS

17 NAME OF FATHER: John Wheeler

18 BIRTHPLACE OF FATHER (City) cannot be learned (State or country)

19 MAIDEN NAME OF MOTHER: Julia Miller

20 BIRTHPLACE OF MOTHER (City) cannot be learned (State or country)

21 Informant Westborough State Hospital records (Address)

A TRUE COPY.

ATTEST: Annie C. Dunne (Registrar of City or Town where death occurred)

DATE FILED March 16, 1953

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12-49-900722

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

5

1 PLACE OF DEATH: Worcester (County); Southborough (City or Town); No. Deerfoot Farms St. Deerfoot Rd. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Albert E. Crepeau (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT: (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 25 Sargent St. St. Cambridge Mass (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: April (Month) 14 (Day) 1953 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Hypertensive heart disease
Mild coronary occlusion
Pulmonary Emphysema
Con pneumonia

5 Accident, suicide, or homicide (specify).....

Date and hour of injury.....19.....

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Walter F Mahoney, M. D.

(Address) Needham Mass Date 4-14 1953

7 Cambridge Catholic Cambridge, Mass
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL April 17 1953

8 NAME OF FUNERAL DIRECTOR Frank Robichaud

ADDRESS 125 Rindge Ave, Cambridge, Mass.

Received and filed April 15 1953

John J. Toberi
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	White	married

11a If married, widowed, or divorced
HUSBAND of MADELINE HAYES
(Give maiden name of wife in full)

(or) WIFE of —
(Husband's name in full)

12 IF STILLBORN, enter that fact here. —

13 AGE 40 Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Milkman.
(Kind of work done during most of working life)

15 Industry or Business: Deerfoot Farms Co.

16 Social Security No. 028 - 09 - 2305

17 BIRTHPLACE (City) Cambridge, Mass.
(State or country)

PARENTS

18 NAME OF FATHER Adrean Crepeau

19 BIRTHPLACE OF FATHER (City)
(State or country) Canada

20 MAIDEN NAME OF MOTHER Eugenia LeClair

21 BIRTHPLACE OF MOTHER (City)
(State or country) Canada

22 Informant Mrs. Madeline Crepeau
(Address) 25 Sargent St, Cambridge, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Shone
(Signature of Agent of Board of Health or other)

Agent, Board of Health 4/14/53
(Official Designation) (Date of Issue of Permit)

FORM R-303 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

25M (D)-12-49-900722

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 6

PLACE OF DEATH

1 (County) Worcester

(City or Town) (Westboro) Southboro

No. Deerfoot Farms St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Augustin Levesque
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) WW(2)

(a) Residence. No. 19, Hawthorn Ave. St. Methuen Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 4 1953
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death (presumably Coronary thrombosis

5 Accident, suicide, or homicide (specify).....

Date and hour of injury.....19.....

Where did Injury occur?.....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?.....
(Specify type of place)

Manner of Injury.....
(How did injury occur?)

Nature of Injury.....

While at work?..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) Walter F. Mahoney, M. D.

(Address) Westborough Mass Date May 4 1953

7 Sacred Heart Andover Mass.
Place of Burial, or Cremation (City or Town)

DATE OF BURIAL 5-7-53 19.....

8 NAME OF FUNERAL DIRECTOR JOseph H. Couture

ADDRESS 375, Haverhill St. Lawrence Mass.

Received and filed.....19 53

John J. Rakeni
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Single

11a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 48 Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Farmhand
(Kind of work done during most of working life)

15 Industry or Business: Farming

16 Social Security No. 018-07-1866

17 BIRTHPLACE (City) Lawrence Mass.
(State or country)

PARENTS

18 NAME OF FATHER Joseph Levesque

19 BIRTHPLACE OF FATHER (City) Canada
(State or country)

20 MAIDEN NAME OF MOTHER Odina Roy

21 BIRTHPLACE OF MOTHER (City).....
(State or country) Canada

22 Informant Mrs. Eva Lemay (sister)
(Address) 19, Hawthorne Ave. Methuen Mass

I HEREBY CERTIFY that a satisfactory certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd. of Health May 4 1953
(Official Designation) (Date of Issue of Permit)

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L. as amended by Chap. 48, Acts of 1927 and Chap. 414, Acts of 1931.

No undertaker or other person shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.....Chap. 114, Sec. 46, G. L., as amended.

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead.....— General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

.....The medical examiner certifies the cause and manner of death to the best of his knowledge and belief.

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a steam railway accident." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1)Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

SPACE FOR ADDITIONAL INFORMATION Unable to locate discharge

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 7

1 PLACE OF DEATH
Worcester (County)
Southboro (City or Town)
No. Connors Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Grace M Smith
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 8 Walker St St. Marlboro Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 4 years ... months ... days. In place of residence ... years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 8 1953
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1953, to June 8, 1953
I last saw her alive on June 7, 1953, death is said to have occurred on the date stated above, at 5:05 a.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) Sclerotic Heart Disease	3 mo
ANTECEDENT CAUSES	Due To (b) Arteriosclerosis	years
	Due To (c)	
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations no operation

Date of operation ... Was autopsy performed? ...

What test confirmed diagnosis? ...

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify ...
(Signed) C. W. L. Smith, M. D.
(Address) Marlboro Date 6-8 1953

6 Burial Southboro Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 10 1953

7 NAME OF FUNERAL DIRECTOR William M Tighe
ADDRESS Marlboro Mass

Received and filed June 12 1953
John J. Raleni (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR OR RACE White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) Single

10a If married, widowed, or divorced HUSBAND of ...
(Give maiden name of wife in full)
(or) WIFE of ...
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years ... Months ... Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Clerk
(Kind of work done during most of working life)

14 Industry or Business Framingham Nat Bank

15 Social Security No. 019-16-8243

16 BIRTHPLACE (City) (State or country) Southboro Mass

PARENTS

17 NAME OF FATHER Fred Smith

18 BIRTHPLACE OF FATHER (City) (State or country) can not be learned

19 MAIDEN NAME OF MOTHER Letitia Thompson

20 BIRTHPLACE OF MOTHER (City) Southboro (State or country) Mass

21 Informant Aubrey Borden
(Address) Bishop Rd Sudbury Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Bd of Health 6-8-53
(Official Designation) (Date of Issue of Permit)

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

50M (A)-1-51 903586

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-1-52-906135

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 9

1 PLACE OF DEATH
Worcester (County)
Southborough (City or Town)
No. Turnpike Rd St. Fayville (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Irmgard Julia Noberini (nee Schiller)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Rd St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 4 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 9 (Day) 1953 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Asphyxiation by gas and plaster dust

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury June 9 1953
Where did Injury occur? S Southborough Mass
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Home
(Specify type of place)
Manner of Injury Tornado
(How did injury occur?)
Nature of Injury asphyxiation - gas - dust
While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Walter F Mahoney, M. D.
(Address) Southborough Mass Date 6-9 1953

7 Rural Southboro
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL June 12 1953

8 NAME OF FUNERAL DIRECTOR William M Tighe
ADDRESS Marlboro Mass

Received and filed June 12 1953
John L Palermo
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female | 10 COLOR OR RACE White | 11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Divorced

11a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Robert Noberini
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 27 Years Months Days | If under 24 hours Hours Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. 019-26-6564

17 BIRTHPLACE (City) Lindau Germany
(State or country)

PARENTS

18 NAME OF FATHER John Schiller

19 BIRTHPLACE OF FATHER (City)
(State or country) Germany

20 MAIDEN NAME OF MOTHER can not be learned

21 BIRTHPLACE OF MOTHER (City)
(State or country) Germany

22 Informant Robert Noberini Husband
(Address) Turnpike Rd Fayville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Fina Tom P. Stone
(Signature of Agent of Board of Health or other)
Agent Bd of Health 6-11-53
(Official Designation) (Date of Issue of Permit)

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-1-52-906135

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 8

1 PLACE OF DEATH
(County) Worcester
(City or Town) Southborough
No. Turnpike Rd St. Fayville (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert J. Noberini Jr
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Rd. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years months 6 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 9 (Day) 1953 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Asphyxiation by gas and plaster dust

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury June 9 1953
Where did Injury occur? Southborough Mass
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Home
(Specify type of place)
Manner of Injury Jumped
(How did injury occur?)
Nature of Injury asphyxiation by gas and dust
While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Walter F Mahoney, M. D.
(Address) Westborough Mass Date 6-9 1953

7 Rural Southboro
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL June 12 1953

8 NAME OF FUNERAL DIRECTOR William M Fiske
ADDRESS Marlboro Mass

Received and filed June 12 1953
John F. Roberts
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male | 10 COLOR OR RACE White | 11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Single

11a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 1 Years Months 6 Days | If under 24 hours Hours Minutes

14 Usual Occupation: —
(Kind of work done during most of working life)

15 Industry or Business: —

16 Social Security No. —

17 BIRTHPLACE (City) (State or country) Framingham Mass

PARENTS

18 NAME OF FATHER Robert J. Noberini

19 BIRTHPLACE OF FATHER (City) (State or country) Framingham

20 MAIDEN NAME OF MOTHER Irmgard Schiller

21 BIRTHPLACE OF MOTHER (City) (State or country) Germany

22 Informant Robert Noberini Father
(Address) Turnpike Rd Fayville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent Bd of Health June 11 1953
(Official Designation) (Date of Issue of Permit)

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50m-(g)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 10

PLACE OF DEATH

1 (County) Worcester

(City or Town) Southborough

No. Family Post Office - Turnpike Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Florence Trioli

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Rd. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 18 years ..... months ..... days. In place of residence 15 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 9 (Day) 1953 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Multiple Fractures Chest - Abdomen Legs.

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury June 9 1953

Where did Injury occur? Southborough Mass
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Home
(Specify type of place)

Manner of Injury Automobile
(How did injury occur?)

Nature of Injury Multiple fractures chest-abdomen legs

While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Walter F. Wadsworth, M. D.

(Address) Northborough Date 6-9 1953

7 Burial (Cemetery) Southborough
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL June - 12 - 1953

8 NAME OF FUNERAL DIRECTOR Henry C. Pratt & Son

ADDRESS 122 Main St. Marlboro Mass

Received and filed June 13 1953

John J. Palmer
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female

10 COLOR OR RACE White

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of James Trioli
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 42 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Asst Postmaster
(Kind of work done during most of working life)

15 Industry or Business: U.S. Post Office

16 Social Security No.

17 BIRTHPLACE (City) Marlboro
(State or country) Mass.

PARENTS

18 NAME OF FATHER Charles J. Jaarsma

19 BIRTHPLACE OF FATHER (City) Unknown
(State or country) Holland

20 MAIDEN NAME OF MOTHER Trina Smith

21 BIRTHPLACE OF MOTHER (City) Unknown
(State or country) Holland

22 Informant
(Address) James Trioli Turnpike Rd - Family

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy Prentiss
(Signature of Agent of Board of Health or other)

Agent Bd of Health 6-12-53
(Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough (City or town making return)

Registered No. 126

PLACE OF DEATH

1 Middlesex (County)

Marlborough (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret M. Campbell (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Northboro Road (Usual place of abode) Southboro, Mass (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 5 days. In place of residence 15 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 5, 1953 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 1, 1953, to July 5, 1953

I last saw h... alive on July 1, 1953, death is said to have occurred on the date stated above, at 8.05A m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a)	Hypertensive arterio sclerotic heart disease	5 yr
ANTECEDENT CAUSES Due To (b)	Hypertension	30 Yr
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations.....

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) John Paul Ahearn M. D.

(Address) Marlborough Date 7-5-53 19....

6 Rural Southboro, Mass

Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 8, 1953 19....

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westboro, Mass

Received and filed August 11, 1953

John J. Baker

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	White	Single

10a If married, widowed, or divorced

HUSBAND of..... (Give maiden name of wife in full)

(or) WIFE of..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 68 Years 2 Months 24 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: housework (Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. none

16 BIRTHPLACE (City) Nova Scotia (State or country)

PARENTS

17 NAME OF FATHER John A. Campbell

18 BIRTHPLACE OF FATHER (City) Nova Scotia (State or country)

19 MAIDEN NAME OF MOTHER Annie Patterson

20 BIRTHPLACE OF MOTHER (City) Nova Scotia (State or country)

21 Informant James B. Johnson

(Address) Southboro, Mass

A TRUE COPY ATTEST: F. J. Bertrand

(Registrar of City or Town where death occurred)

DATE FILED July 9, 1953 19....

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN, SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 11-12

1 PLACE OF DEATH: Worcester (County) — Southborough (City or Town) — No. Central St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Florence Ethel Uhlman (Nee Winch)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Central St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 54 years 8 months ? days. In place of residence 54 years 8 months ? days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: July (Month) 16 (Day) 1953 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1945 to July 16, 1953
I last saw her alive on July 15, 1953, death is said to have occurred on the date stated above, at 12-05 A m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) Pneumonia	12 days
ANTECEDENT CAUSES	Due To (b)	
	Due To (c)	
OTHER SIGNIFICANT CONDITIONS	Abdominal neoplasm probably malignant	3 yrs +

Major findings: Of operations Hysterectomy
Date of operation 1924 Was autopsy performed? No
What test confirmed diagnosis? Physical examination

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Roland S Newman, M. D.
(Address) Central Westboro Date July 16 1953

6 Central Cem. Southborough
Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 5 1953

7 NAME OF FUNERAL DIRECTOR Richard D Caldwell
ADDRESS 21 Cottage Av. Marlboro

Received and filed July 17 1953
John J. Rafferty (Registrar)

50M-2-49-25666

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
female	white	married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Douglas Thorpe Uhlman
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 71 Years 9 Months 10 Days | If under 24 hours: Hours Minutes

13 Usual Occupation: housewife
(Kind of work done during most of working life)

14 Industry or Business: home

15 Social Security No. none

16 BIRTHPLACE (City) Framingham Mass.
(State or country)

PARENTS

17 NAME OF FATHER Reuben Winch

18 BIRTHPLACE OF FATHER (City) unascertainable
(State or country)

19 MAIDEN NAME OF MOTHER Arvilla Perry

20 BIRTHPLACE OF MOTHER (City) Natick
(State or country) Mass

21 Informant Mrs Jean Packard
(Address) Central St. Southborough Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy A Shore
(Signature of Agent of Board of Health or other)
Agent, Board of Health 7-16-53
(Official Designation) (Date of Issue of Permit)

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-1-52-906135

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 13

PLACE OF DEATH

1 Worcester (County)
Southboro Mass. (City or Town)

No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James R. Sherrell
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Newton St St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death .....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug (Month) 17 (Day) 1953 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary thrombosis

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury .....19.....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....
(How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Mass Date Aug 17 1953

7 Rural Cemetery Southboro Mass
Place of Burial, or Cremation (City or Town)

DATE OF BURIAL Aug 19 1953

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro Mass

Received and filed Aug 22 1953

Frances E. Rabesa
(Registrar)

Asst Clerk

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	W	Widower

11a If married, widowed, or divorced
HUSBAND of Geraldine Teller Sherrell
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 42 47 Years 9 Months 12 Days | If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Machinist
(Kind of work done during most of working life)

15 Industry or Business: St Marks School Southboro Mass.

16 Social Security No. 010-18-5261

17 BIRTHPLACE (City) Dundee Scotland
(State or country)

PARENTS

18 NAME OF FATHER Cannot be learned

19 BIRTHPLACE OF FATHER (City) Scotland
(State or country)

20 MAIDEN NAME OF MOTHER Cannot be learned

21 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country)

22 Informant Mrs Hector Duplessis
(Address) RD 1 Lakeside Ave Marlboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Shea
(Signature of Agent of Board of Health or other)

Agent Bd of Health
(Official Designation)

Aug 18 1953
(Date of Issue of Permit)

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12.49-900722

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 14

PLACE OF DEATH

1 Worcester (County)
Southboro Mass (City or Town)
No. Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alfred Di Pesa
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Main St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 25 53
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

sudden death
presumably Coronary thrombosis

5 Accident, suicide, or homicide (specify).....

Date and hour of injury.....19.....

Where did Injury occur?.....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?.....
(Specify type of place)

Manner of Injury.....
(How did injury occur?)

Nature of Injury.....

While at work?.....Was autopsy performed?.....

6 Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) V alter Mathews M. D.

(Address) Brough Date 8-27 19 53

7 Holyhood Cemetery Brookline Mass
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Aug 28 1953

8 NAME OF FUNERAL DIRECTOR Ezekiel C Morris

ADDRESS Main St Southboro Mass

Received and filed August 31 1953

John J. Fabeni
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX M

10 COLOR OR RACE W

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

11a If married, widowed, or divorced HUSBAND of Maria Le Voggi (Di Pesa)
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 76 Years 1 Months 15 Days | If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Hotel Proprietor & Mgr.
(Kind of work done during most of working life)

15 Industry or Business: Hotel owner.

16 Social Security No. 028-05-6102

17 BIRTHPLACE (City) NAPLES
(State or country) ITALY

PARENTS

18 NAME OF FATHER Morsino Di Pesa

19 BIRTHPLACE OF FATHER (City).....
(State or country) Italy

20 MAIDEN NAME OF MOTHER Cannot be learned

21 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country)

22 Informant Mrs Maria Le Voggi Di Pesa
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Bone
(Signature of Agent of Board of Health or other)

Agent Board of Health 8-27-53
(Official Designation) (Date of Issue of Permit)

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN, SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 15

1 PLACE OF DEATH: Worcester (County) — Southborough (City or Town)

No. Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alice May Draper (nee Glover) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Main St. Southborough (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 56 years 7 months ..... days. In place of residence 56 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 30 (Day) 1953 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1953, to Aug 30, 1953

I last saw her alive on Aug 30 1953 death is said to have occurred on the date stated above, at ..... m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Coronary occlusion	30 days
ANTECEDENT CAUSES Due To (b)	Arterio Sclerosis	20 yrs +
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	none	

Major findings: Of operations none

Date of operation — Was autopsy performed? —

What test confirmed diagnosis? Physical examination

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Roland A Newton, M. D.

(Address) 9 Central Westboro Date Aug 30 1953

6 Maplewood Cem. Marlboro (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL Sept 2, 1953

7 NAME OF FUNERAL DIRECTOR Richard P Caldwell

ADDRESS 21 Cottage Ave. Marlboro

Received and filed Sept. 2 1953

John J. Babeu (Registrar)

50M-2-49-25666

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female | 9 COLOR OR RACE white | 10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) widowed

10a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Allan Howe Draper (Husband's name in full)

11 IF STILLBORN, enter that fact here. —

12 AGE 78 Years 8 Months 15 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: home

15 Social Security No. no

16 BIRTHPLACE (City) marlborough (State or country) Mass

PARENTS

17 NAME OF FATHER Isaac S. Glover

18 BIRTHPLACE OF FATHER (City) Hebron (State or country) Maine

19 MAIDEN NAME OF MOTHER Abbie J. Gleason

20 BIRTHPLACE OF MOTHER (City) marlborough (State or country) Mass

21 Informant (Address) Mrs Mary Bullard (Daughter) Southboro mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Shone (Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) 8-31-53 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

16

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Westborough
(City or town making return)

Registered No. 233

1 PLACE OF DEATH: Worcester (County); Westboro (City or Town)

No. Westboro State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harry A. McMaster
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Latisquama Road St. Southborough, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 20 days. In place of residence ....years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 11, 1953
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1953, to Oct. 11, 1953
I last saw him alive on Oct. 11, 1953, death is said to have occurred on the date stated above, at 11:30A m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Myocardial Degeneration	2 wks
ANTECEDENT CAUSES Due To (b)	Generalized Arteriosclerosis	Unk.
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations.....

Date of operation.....Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) C. A. Brown M. D.
(Address) State Hospital Date Oct. 11 1953

6 Rural Cemetery Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Oct. 13 1953

7 NAME OF FUNERAL DIRECTOR Cookson Funeral Home
ADDRESS 318 Union Ave., Framingham

Received and filed November 6 1953
Frances E. Roberts
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Widowed

10a If married, widowed, or divorced
HUSBAND of Charlotte Lincoln
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years....Months....Days | If under 24 hours ....Hours....Minutes

13 Usual Occupation: Retired
(Kind of work done during most of working life)

14 Industry or Business: Salesman

15 Social Security No.....

16 BIRTHPLACE (City) Sharon
(State or country) Mass.

PARENTS

17 NAME OF FATHER Henry Austin McMaster

18 BIRTHPLACE OF FATHER (City) Hancock,
(State or country) N. H.

19 MAIDEN NAME OF MOTHER Mary Rymes

20 BIRTHPLACE OF MOTHER (City) cannot be learned
(State or country)

21 Informant Westboro State Hospital
(Address) records

A TRUE COPY.
ATTEST: Annie A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED Oct. 15 1953

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 17

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

No. Cordaville Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harry L. Ladd
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. Cordaville Rd. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 57 years ..... months ..... days. In place of residence 57 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 2 (Day) 1953 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 15 July, 1949, to 2 November, 1953

I last saw him alive on 31 October, 1953, death is said to have occurred on the date stated above, at 7:15 A. m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) Arteriosclerotic Heart Disease	6 yrs
ANTECEDENT CAUSES	Due To (b) Generallized Arterio-sclerosis	6+ yrs
	Due To (c) —	
OTHER SIGNIFICANT CONDITIONS	Bronchiectasis	6+ yrs

Major findings: Of operations: none

Date of operation — Was autopsy performed? no

What test confirmed diagnosis? clinical.

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Timothy P. Stone, M. D.

(Address) Southboro, Mass. Date Nov. 2 1953

6 Riverside Springvale Maine
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 4 1953

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS 62 W. Main St. Westboro, Mass.

Received and filed November 11 1953

John J. Raleigh (Registrar)

50M-3-53-909098

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Widowed

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Addie Pillsbury
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 5 Months 24 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Engineer
(Kind of work done during most of working life)

14 Industry or Business: Mill

15 Social Security No. 019-12-5996A

16 BIRTHPLACE (City) Turner (State or country) Maine

PARENTS

17 NAME OF FATHER Can not be learned

18 BIRTHPLACE OF FATHER (City) Can not be learned (State or country) Maine

19 MAIDEN NAME OF MOTHER Can not be learned

20 BIRTHPLACE OF MOTHER (City) Can not be learned (State or country) Maine

21 Informant Mrs. William S. McKie
(Address) Cordaville Rd. Southboro, Mas

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of Health 11.2.53
(Official Designation) (Date of Issue of Permit)

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12-49-900722

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 15 17

PLACE OF DEATH

1 Worcester (County)
Southborough (City or Town)
No. E. Main St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Arline G Morrison
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. St. Marks School,
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 29 1953
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Thrombosis

5 Accident, suicide, or homicide (specify).....

Date and hour of injury.....19.....

Where did Injury occur?.....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?.....
(Specify type of place)

Manner of Injury.....
(How did injury occur?)

Nature of Injury.....

While at work?..... Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Walter F Cushman, M. D.

(A dress) Hopkinton Mass Date Nov 29 1953

7 Evergreen Cemetery, Hopkinton Mass
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Dec 1 1953

8 NAME OF FUNERAL DIRECTOR Donald C Morris

ADDRESS Main St Southboro Mass

Received and filed Dec 2 1953

Frances E Rabeur
(Registrar)
asst clerk

PERSONAL AND STATISTICAL PARTICULARS

9 SEX F

10 COLOR OR RACE W

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) single

11a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 45 Years 4 Months 9 Days | If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Laundry Supervisor
(Kind of work done during most of working life)

15 Industry or Business: School Laundry

16 Social Security No. 030-05-1541

17 BIRTHPLACE (City) Marlboro
(State or country) Mass

PARENTS

18 NAME OF FATHER George A Morrison

19 BIRTHPLACE OF FATHER (City) Londonderry
(State or country) N. H.

20 MAIDEN NAME OF MOTHER M. Edith Dudley

21 BIRTHPLACE OF MOTHER (City) Candia
(State or country) N H

22 Informant Mrs Alice M Bashaw
(Address) Woodville Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

agent Bd of Health Nov 30, 1953
(Official Designation) (Date of Issue of Permit)

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 19

1 PLACE OF DEATH: Worcester (County) / Fayville (City or Town)

No. Turnpike Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Clementina Triolì nee Cordani (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Rd St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 25 years ..... months ..... days. In place of residence ..... years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 5 1953 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan, 1948 to Dec 5, 1953

I last saw her alive on Dec 5, 1953, death is said to have occurred on the date stated above, at 11 A m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral hemorrhage	2 day
ANTE CEDENT CAUSES Due To (b) Generalized Sclerosis	5 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation..... Was autopsy performed? No

What test confirmed diagnosis? Statistics

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) Walter F Mahoney M. D.

(Address) Hudson Date Dec 5 1953

6 Burial, Cremation or Removal Place of Burial or Cremation Southboro Mass (City or Town)

DATE OF BURIAL Dec 11. 1953

7 NAME OF FUNERAL DIRECTOR William M Tighe

ADDRESS 7 Winbor ST Marlboro Mass

Received and filed Dec 11 1953

A TRUE COPY ATTEST: John J. Patenaude

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced HUSBAND of..... (Give maiden name of wife in full)

(or) WIFE of John J. Triolì (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: —

15 Social Security No. —

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER can not be learned

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER can not be learned

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant (Address) Mrs Thomas O'Brien Daughter Turnpike Rd Fayville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) 12 8 53 (Date of Issue of Permit)

50M (AJ-1-51 903566

FORM R-301

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 20

PLACE OF DEATH

1 Worcester (County)
Southboro Mass (City or Town)

No. Lone Lane St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Walter William Collins (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Lone Lane St. Southboro Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 14 (Day) 1953 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1949, to Dec 14, 1953

I last saw him alive on Dec 13, 1953, death is said to have occurred on the date stated above, at 7:15 A m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Bronchopneumonia, terminal, due to debility + starvation due to	2 days
ANTECEDENT CAUSES Due To (b) Cerebral softening	20 months
Due To (c) Arteriosclerosis	5+ years
OTHER SIGNIFICANT CONDITIONS —	

Major findings:
Of operations.....none.....
Date of operation.....— Was autopsy performed?.....no.....
What test confirmed diagnosis?.....clinical.

5 Was disease or injury in any way related to occupation of deceased?.....no.....
If so, specify.....
(Signed) Timothy P. Stone, M. D.
(Address) Main St, Southboro, Mass. Date 12 15 1953

6 Beverly Farms Cemetery
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Dec 16 1953

7 NAME OF FUNERAL DIRECTOR Donald C Morris
ADDRESS Main St Southboro Mass.

Received and filed ..... 19..... John J. Gabens (Registrar)
A TRUE COPY ATTEST: .....

50M (A)-1-51 903566

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	W	Married

10a If married, widowed, or divorced
HUSBAND of Muriel Nixon
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years 7 Months 7 Days — If under 24 hours .....Hours .....Minutes

13 Usual Occupation: Gardner
(Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 019-26-7019

16 BIRTHPLACE (City) (State or country) Millbrook Jersey Channel Isle England

PARENTS

17 NAME OF FATHER Giles Collins

18 BIRTHPLACE OF FATHER (City) (State or country) Dorset, England

19 MAIDEN NAME OF MOTHER Ellen Moore

20 BIRTHPLACE OF MOTHER (City) (State or country) Dorset England

21 Informant (Address) Mrs Muriel (Nixon) Collins Lone Lane Southboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Bd of Health (Official Designation) Dec 15, 1953 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 21

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Fram. Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charlotte Fantony (McGovern) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Road St. (Fayville) Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death years 2 months 16 days. In place of residence 5 (approx) years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 21, 1953. (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 9/6/53, 19..., to 12/21/53, 19...

I last saw her alive on 12/20/53, 19..., death is said to have occurred on the date stated above, at 4:20 a.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) peritonitis generalized volvulus small bowel	10 days
ANTECEDENT CAUSES	Due To (b) ulcerative colitis	1 yr.
	Due To (c)	
OTHER SIGNIFICANT CONDITIONS	malfunctioning	6 wks.

Major findings: Of operations Ileostomy & Ulcerative colitis

Date of operation 11/10/53-12/1/53-12/8/53 Was autopsy performed? yes

What test confirmed diagnosis? operations

5 Was disease or injury in any way related to occupation of deceased? ...
If so, specify

(Signed) Lee G. Kendall, M. D.
(Address) Framingham, Mass. Date 12/21 1953

6 Rural Cemetery - Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Dec. 24, 1953 19...

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Southboro, Mass.

Received and filed ... 1953
Dec 31
John J. Gahen
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: fem | 9 COLOR OR RACE: white | 10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): married

10a If married, widowed, or divorced
HUSBAND of ...
(Give maiden name of wife in full)
(or) WIFE of Joseph A. Fantony
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 26 Years 8 Months 23 Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: housewife
(Kind of work done during most of working life)

14 Industry or Business: ...

15 Social Security No. 026-20-1844

16 BIRTHPLACE (City) Framingham, Mass.
(State or country)

PARENTS

17 NAME OF FATHER Henry P. McGovern

18 BIRTHPLACE OF FATHER (City) Framingham, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Edwina T. Smith

20 BIRTHPLACE OF MOTHER (City) Portland, Maine
(State or country)

21 Informant Joseph A. Fantony
(Address) Turnpike Rd. Southboro

A TRUE COPY
ATTEST: ...
(Registrar of City or Town where death occured)

DATE FILED Dec. 23, 1953. 19...

FORM R-303 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12-49-900722

MARGIN RESERVED FOR BINDING

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. /

PLACE OF DEATH

1 Worcester (County)
Southborough (City or Town)

No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John J. Cocker (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Pleasant St (Usual place of abode) St. Foxville (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan 16 1954 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary thrombosis

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19.....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Walter F Mahoney, M. D.

(Address) Northborough Mass Date Jan 16 1954

7 Rural Cemetery Southboro Mass
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Jan 19 1954

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St Southboro Mass

Received and filed Jan 21 1954

Frances E Ribeiro (Registrar)
asst Clerk

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: M

10 COLOR OR RACE: W

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word): married

11a If married, widowed, or divorced HUSBAND of Rose Mitchell (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 67 Years 9 Months 23 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Gas station Proprietor (Kind of work done during most of working life)

15 Industry or Business: Gasoline & oil

16 Social Security No. 014-16-5043

17 BIRTHPLACE (City) Ashton Lyne (State or country) England

PARENTS

18 NAME OF FATHER John Cocker

19 BIRTHPLACE OF FATHER (City) ..... (State or country) England

20 MAIDEN NAME OF MOTHER Rose Anne Donoghue

21 BIRTHPLACE OF MOTHER (City) cannot not be learned (State or country)

22 Informant Mrs Rose (Mitchell) Cocker
(Address) Pleasant St Foxville Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Irving P. Stone.
(Signature of Agent of Board of Health or other)

Agent Bd of Health 1 18 54
(Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-10-53-910621

Jurisdiction Waived

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Boston
(City or town making return)

Registered No. 849 2

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town)

No. N.E.Deaconess Hospt St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anna T Pinkham 2
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Richards Road St. Southboro Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 18½ Hrs years months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan. 28/54
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1954 to Jan. 28/54 19

I last saw her alive on Jan. 28/54 19, death is said to have occurred on the date stated above, at 8:25A m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH ½ Hr

ANTECEDENT CAUSES Due To (b) Cancer left breast with widespread metastases — 4 Yrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

Major findings: Of operations Cancer lt. breast with widespread metastases

Date of operation 1950 Was autopsy performed? Yes

What test confirmed diagnosis? histological sections

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) M P Osborne M. D.

(Address) Brookline Mass Date 1-28 19 54

6 Rural Cem-Southboro Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 30/54 19

7 NAME OF FUNERAL DIRECTOR D C Morris

ADDRESS Southboro Mass.

Received and filed Feb 2 19 54

Edward J. Rakun
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	W	Married

10a If married, widowed, or divorced HUSBAND of Joseph W Pinkham
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 71 Years 8 Months 6 Days — If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Housewife

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Sweden

PARENTS

17 NAME OF FATHER Frederick Peterson

18 BIRTHPLACE OF FATHER (City) (State or country) Sweden

19 MAIDEN NAME OF MOTHER ---

20 BIRTHPLACE OF MOTHER (City) (State or country) Sweden

21 Informant J W Pinkham
(Address) Richards Rd. Southboro Mass.

A TRUE COPY
ATTEST: Marion E. Mackie
(Registrar of City or Town where death occurred)

DATE FILED Feb. 1/54 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

WORCESTER (City or town making return)

Registered No. 3

1 PLACE OF DEATH: WORCESTER (County); WORCESTER (City or Town)

No. ____ St. Shattuck Nursing Home (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alice L Priest (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) ---

(a) Residence. No. ____ St. ____ (Usual place of abode) Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death ____ years 2 months ____ days. In place of residence 1 years 1 months ____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 15, 1954 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 12-31, 1953, to Feb 15, 1954

I last saw her alive on 2-14, 1954, death is said to have occurred on the date stated above, at 8:15 A.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	broncho pneumonia	6 wks
ANTECEDENT CAUSES Due To (b)	chronic myocarditis	10 yrs
Due To (c)	arteriosclerosis primary	10 yrs
OTHER SIGNIFICANT CONDITIONS	senility	

Major findings:
Of operations ____
Date of operation ____ Was autopsy performed? ____
What test confirmed diagnosis? ____

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify ____
(Signed) Carleton T Smith, M. D.
(Address) 36 Pleasant St. West Northfield Date 2-15, 1954

6 Place of Burial or Cremation Cem (City or Town) Northfield, Mass
DATE OF BURIAL Feb 17, 1954

7 NAME OF FUNERAL DIRECTOR Geo Sessions for Geo Sessions Sons Co
ADDRESS Worcester Mass

Received and filed Mar 10 1954
Frances E. Palmer
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	single

10a If married, widowed, or divorced
HUSBAND of ____ (Give maiden name of wife in full)
(or) WIFE of ____ (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 10 Months 18 Days | If under 24 hours ____ Hours ____ Minutes

13 Usual Occupation: At home (Kind of work done during most of working life)

14 Industry or Business: ____

15 Social Security No. ____

16 BIRTHPLACE (City) Northfield (State or country) Mass.

PARENTS

17 NAME OF FATHER Dwight S Priest

18 BIRTHPLACE OF FATHER (City) Northfield (State or country) Mass.

19 MAIDEN NAME OF MOTHER Susan M Caldwell

20 BIRTHPLACE OF MOTHER (City) Northfield (State or country) Mass.

21 Informant (Address) Dwight E Priest

A TRUE COPY
ATTEST: Robert J. O'Keefe
(Registrar of City or Town where death occurred)

DATE FILED Feb 17, 1954

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-(B)-11-51-905807

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH (City or town making return)

Registered No. 39 - 4

1 PLACE OF DEATH: MIDDLESEX (County); MARLBOROUGH (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Katherine Lane (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Middle Road (Usual place of abode) Southboro, Mass (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 17, 1954 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1954, to Feb 17, 1954

I last saw her alive on Feb 17, 1954, death is said to have occurred on the date stated above, at 1.30 A.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Acute gastrointestinal hemorrhage	30 hr
ANTECEDENT CAUSES Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis? Exam

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Marilyn M. Merserve, M. D.

(Address) Southboro Date 2-17-54 19

6 Rural Cemetery Southboro, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 19, 1954 19

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass

Received and filed Feb 19 1954

John L. Lahene
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	W	Married

10a If married, widowed, or divorced
HUSBAND of..... (Give maiden name of wife in full)
(or) WIFE of Howard P. Lane (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 3 Months 4 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Bathurst, N.B.

PARENTS

17 NAME OF FATHER Thomas Kerr

18 BIRTHPLACE OF FATHER (City) Bathurst, N.B. (State or country)

19 MAIDEN NAME OF MOTHER Margaret Scott

20 BIRTHPLACE OF MOTHER (City) Bathurst, N.B. (State or country)

21 Informant Charles S. Lane
(Address) Southboro, Mass

A TRUE COPY
ATTEST: Raymond D. Lavallee
(Registrar of City or Town where death occurred)

DATE FILED Feb 19, 1954 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 5

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Boy HAMEL
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Boston Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

STILLBORN

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 11, 1954
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Stillborn 19....., to 3/11/54, 19.....

I last saw h.....alive on....., 19....., death is said to have occurred on the date stated above, at 4:45 pm.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Maccerated Fetus

ANTECEDENT CAUSES Due To (b) Placental sclerosis

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS .....

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) Joseph C. Merriam, M. D.
(Address) Framingham, Mass. Date 3/11 19 54

6 Rural Cemetery, Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 12, 1954. 19

7 NAME OF FUNERAL DIRECTOR Richard P. Coldwell
ADDRESS Marlboro, Mass.

Received and filed Mar 15 19 54
John J. Sabeni
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
male	white	single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here. STILLBORN

12 AGE.....Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation:.....
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Framingham, Mass.
(State or country)

PARENTS

17 NAME OF FATHER Charles F. Hamel

18 BIRTHPLACE OF FATHER (City) Somerville, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Edeanor J. Onthank

20 BIRTHPLACE OF MOTHER (City) Southboro, Mass.
(State or country)

21 Informant Charles Hamel
(Address) Southboro, Mass.

A TRUE COPY
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED March 12, 1954. 19

FORM R-303 A

N. B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

25M (8)-8-50-902 592

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 6

PLACE OF DEATH

1 ~~Middlesex~~ Worcester (County)

Southborough (City or Town)

No. Latisquama Rd., Southborough St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Jennie (Walker) DeMone (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. Latisquama Rd., Southborough Massachusetts (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 12, 1954 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arteriosclerosis,
Acute cardiac insufficiency.
Sudden unexpected and unattended death.

5 Accident, suicide, or homicide (specify) No

Date and hour of injury 19

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) J.H.McCann, M. D.

(Address) Framingham, Date March 12, 1954

7 Rural Cemetery Southboro, Mass. Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL March 15 1954

8 NAME OF FUNERAL DIRECTOR Cookson Funeral Home, Inc.

ADDRESS 318 Union Ave., Framingham

Received and filed March 16 1954

John F. Eakens (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female

10 COLOR OR RACE White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) Married

11a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of James A. DeMone (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 78 Years 8 Months 2 Days

If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Housewife (Kind of work done during most of working life)

15 Industry or Business: housewife

16 Social Security No. none

17 BIRTHPLACE (City) (State or country) Chatam, N.B. Canada

PARENTS

18 NAME OF FATHER James Walker

19 BIRTHPLACE OF FATHER (City) Chatham (State or country) New Brunswick, Canada

20 MAIDEN NAME OF MOTHER Mary MacArthur

21 BIRTHPLACE OF MOTHER (City) Chatham (State or country) New Brunswick, Canada

22 Informant James A. DeMone (Address) Latisquama Rd., Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) March 13, 1954 (Date of Issue of Permit)

Federal Security Agency
U. S. Public Health Service

GEORGIA DEPARTMENT OF PUBLIC HEALTH
CERTIFICATE OF DEATH

State File No. 8813

Custodian's No. 314

BIRTH NO. | Militia Dist. No.

1. Place of Death
County: Muscogee | 3-1061-496
City or Town: Columbus | In City Limits Yes ☒ No ☐ | LENGTH OF STAY (in this place): 1Month
Name of Hosp. or Institution: Saint Francis | LENGTH OF STAY: 1 Month

2. Usual Residence (Where deceased lived. If institution: residence before admission)
State: Mass | County: [illegible]
City or Town: Southboro | In City Limits Yes ☒ No ☐ | LENGTH OF STAY (in this place): 15 Years
Street Address or R. F. D. and Box No.: NONRESIDENT

3. NAME OF DECEASED (Type or Print): a. (First) Louise | b. (Middle) | c. (Last) Sawyer

4. DATE OF DEATH: (Month) April (Day) 18, (Year) 1954

5. SEX: Female | 6. RACE: W | 7. BIRTHPLACE (State or foreign country): Columbus, Georgia | CITIZEN OF WHAT COUNTRY? U S A

15. BURIAL ☒ REMOVAL ☐ CREMATION ☐ | DATE: 4-20-1954 | NAME OF CEMETERY OR CREMATORY: Riverdale

8. DATE OF BIRTH: Dec. 28, 1901 | 9. AGE (In years last birthday): 52 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

LOCATION (City or Town) (County) (State): Columbus, Georgia | 16. EMBALMER'S ADDRESS: Columbus, Georgi

10. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐ | If Married or Widowed Give Name of Spouse: Roland D. Sawyer Jr.

17. EMBALMER'S SIGNATURE: C. H. Torbett | LICENSE NO. 449

11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | KIND OF BUSINESS OR INDUSTRY: Own Home

18. FUNERAL DIRECTOR: D. A. Striffler | LICENSE NO. 546

12. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service) | SOCIAL SECURITY NO.

19. FUNERAL DIRECTOR'S ADDRESS: Columbus, Georgia

13. FATHER'S NAME: James T. Davis

20. INFORMANT: Roland D. Sawyer Jr.

14. MOTHER'S MAIDEN NAME: Annie L. Childs

21. INFORMANT'S ADDRESS: Southboro, Mass.

22. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c) — See Reverse Side

MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	DO NOT WRITE IN THIS SPACE
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Neoplasm of skull probably multiple myeloma		1.
ANTECEDENT CAUSES DUE TO (b)	Neoplasm of skull probably multiple myeloma	unknown	2. 203X 18
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)			3. - 4. 1452
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Acute nephritis sec. to myeloma	? several weeks.	5. 6. 7.

23. DATE OF OPERATION | MAJOR FINDINGS OF OPERATION: Acute nephritis, sec. to myeloma ? several weeks | 24. AUTOPSY? Yes ☐ No ☒

25. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ | PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | INJURY OCCURRED While at Work ☐ Not While at Work ☐

(CITY OR TOWN) (COUNTY) (STATE) | TIME OF INJURY (Month) (Day) (Year) (Hour)

HOW DID INJURY OCCUR?

28. I hereby certify that I attended the deceased from Mar 19 19 54, to Apr 18 19 54, that I last saw the deceased alive on Apr 18 19 54, and that death occurred at 12:30PM., from the causes and on the date stated above.

29. SIGNATURE: Harry H Brice | Degree or Title MD

ADDRESS | DATE SIGNED

29. DATE REC'D BY LOCAL REG. | 27. REGISTRAR'S SIGNATURE

REGISTRAR: CHECK CERTIFICATE CAREFULLY

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(h)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 7

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Jessop (Bowmar)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Road St. Southboro (Fayville)
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 21, 1954.
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fractured right hip

Generalized arteriosclerosis

5 Accident, suicide, or homicide (specify) accident

Date and hour of injury 10:00 a.m. 4/20 19 54

Where did Injury occur? Southboro, Mass.
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Home
(Specify type of place)

Manner of Injury Slipped and fell in living rm.
(How did injury occur?)

Nature of Injury Fractured Right Hip

While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) James F. Vance, M. D.

(Address) Natick, Mass. Date 4/21 19 54

7 Needham Cemetery, Needham, Mass.
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL April 23, 1954. 19

8 NAME OF FUNERAL DIRECTOR Cookson Fun. Home

ADDRESS Framingham, Mass.

Received and filed May 10 19 54

Curtis F. Kelley.
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
fem.	white	widowed

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Thomas Jessop
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 92 Years 1 Months 26 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No.

17 BIRTHPLACE (City) England
(State or country)

PARENTS

18 NAME OF FATHER Thomas Bowmar

19 BIRTHPLACE OF FATHER (City) England
(State or country)

20 MAIDEN NAME OF MOTHER Mary Burton

21 BIRTHPLACE OF MOTHER (City) England
(State or country)

22 Informant Mrs. Allen McLaughlin- Dau.
(Address) Turnpike Rd., Southboro

A TRUE COPY.
ATTEST: [signature]
(Registrar of City or Town where death occurred)

DATE FILED April 23, 1954. 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH
(City or town making return)

Registered No. 87 8

PLACE OF DEATH

1 MIDDLESEX (County)

MARLBOROUGH (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harold E. Fife
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 110 Main St Southboro, St. Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 6 years months days. In place of residence 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 27, 1954
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from January 2 1948, to April 27, 1954

I last saw him alive on April 27, 54, death is said to have occurred on the date stated above, at 7.45 P. m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 dy

ANTECEDENT CAUSES Due To (b) Vascular defect not hypertension

Due To (c)

OTHER SIGNIFICANT CONDITIONS none

Major findings: Of operations none

Date of operation none Was autopsy performed? no

What test confirmed diagnosis? lumbar puncture

5 Was disease or injury in any way related to occupation of deceased?

If so, specify (Signed) Timothy P. Stone M. D.

(Address) Southborough Date Apr 27 1954

Place of Burial or Cremation Rural Cemetery Worcester (City or Town)

DATE OF BURIAL April 30, 1954 19

7 NAME OF FUNERAL DIRECTOR Richard P. Coldwell

ADDRESS Marlborough, Mass

Received and filed April 30, 1954 19

Clinton E. Eddy
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M | 9 COLOR OR RACE W | 10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced HUSBAND of Mary Black
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 63 Years 7 Months 26 Days | If under 24 hours Hours Minutes

13 Usual Occupation: School teacher
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 080-07-1609

16 BIRTHPLACE (City) Manchester, N.H.
(State or country)

PARENTS

17 NAME OF FATHER James W. Fife

18 BIRTHPLACE OF FATHER (City) Suncook, N.H.
(State or country)

19 MAIDEN NAME OF MOTHER Mary A. Fern

20 BIRTHPLACE OF MOTHER (City) Pittsfield, Mass
(State or country)

21 Informant Mrs Mary Fife
(Address) Southboro, Mass

A TRUE COPY
ATTEST: Raymond D. Lavallee
(Registrar of City or Town where death occurred)

DATE FILED April 30, 1954

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-10-53-910621

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

1 PLACE OF DEATH: County SUFFOLK; City or Town BOSTON

BOSTON (City or town making return)

Registered No. 4022

No. N E Center Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME RICHARDSON LEVERICH, JR. (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Residence. No. Sears Road, xxx Southboro, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 28 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 7 (Day) 1954 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 4/9, 19..., to 5/7, 1954

I last saw h... 1m alive on 5/7, 1954, death is said to have occurred on the date stated above, at 1:30a. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Teratocarcinoma testis, rt.	2yrs
ANTECEDENT CAUSES Due To (b) (metastases)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations Retroperitoneal gland metastases

Date of operation 9/16/53 Was autopsy performed? yes

What test confirmed diagnosis? pathological

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) W Leadbetter, M. D.

(Address) 30 Bennet St Date 5/7 1954

6 Newton Place of Burial or Cremation Newton (City or Town)

DATE OF BURIAL Mary 1954

7 NAME OF FUNERAL DIRECTOR P D Wentworth

ADDRESS Waltham Mass

Received and filed June 2 1954

Faustina E Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	W	Married

10a If married, widowed, or divorced
HUSBAND of Jean Presbrey
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 31 Years 10 Months 23 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Salesman
(Kind of work done during most of working life)

14 Industry or Business: - - -

15 Social Security No. - - -

16 BIRTHPLACE (City) New Orleans,
(State or country) La.

PARENTS

17 NAME OF FATHER Richardson Leverich, Sr.

18 BIRTHPLACE OF FATHER (City) New Orleans,
(State or country) La.

19 MAIDEN NAME OF MOTHER Katharine Sewall

20 BIRTHPLACE OF MOTHER (City) Waltham, Mass
(State or country)

21 Informant K Proudfoot
(Address)

A TRUE COPY
ATTEST: Charles H Mackie
(Registrar of City or Town where death occurred)

DATE FILED May 10 19 54

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 10

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town)

No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Milford W Homelin
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) World War I

(a) Residence. No. Winchester St St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 12 years ..... months ..... days. In place of residence 12 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: May (Month) 30 (Day), 1954 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1940, to May 30, 1954

I last saw her alive on May 29, 1954, death is said to have occurred on the date stated above, at 12.35 a.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Coronary occlusion	1 dy.
ANTECEDENT CAUSES Due To (b)	Arterio Sclerotic heart disease	2 yrs.
Due To (c)	Chronic Glomerular nephritis	1 yr.
OTHER SIGNIFICANT CONDITIONS	Rheumatoid arthritis	14 yrs.

Major findings:
Of operations .....
Date of operation ..... Was autopsy performed? no.
What test confirmed diagnosis? Hospital exam + findings

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) William J. Delaney, M. D.
(Address) 136 Main St Date 5/31/1954

6 St Marys Cemetery Marlboro Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 2 1954

7 NAME OF FUNERAL DIRECTOR Donald C Morris
ADDRESS Main St Southboro Mass

Received and filed June 2 1954
Alston & Kelly
(Registrar)

A TRUE COPY ATTEST: .....

50M (A)-1-51 903586

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
MALE	White	married

10a If married, widowed, or divorced HUSBAND of Agnes Girard
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years 4 Months 24 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: (Retired) Construction
(Kind of work done during most of working life)

14 Industry or Business: City Employee

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Whitehall N Y.

PARENTS

17 NAME OF FATHER Abraham Homelin

18 BIRTHPLACE OF FATHER (City) (State or country) Chogey N Y.

19 MAIDEN NAME OF MOTHER Helen Dunkin

20 BIRTHPLACE OF MOTHER (City) (State or country) Chogey N Y.

21 Informant Mrs Agnes (Girard) Homelin
(Address) Winchester St Southboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent or Board of Health or other)

Agent, Bd of Health
(Official Designation)

6-1-54
(Date of Issue of Permit)

EXTRACTS
FROM THE LAWS OF THE
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of only such persons as are supposed to have died by violence. If a medical examiner has notice that there is within his county the body of such a person, he shall forthwith go to the place where the body lies and take charge of the same; . . . General Laws, Chap. 38, Sec. 6.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE Sept 19, 1916

DATE OF DISCHARGE June 27, 1919

RANK, RATING Pvt.

ORGANIZATION AND OUTFIT L Co 104th Inf Reg 26 Y.D.

SERVICE NUMBER 73545

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-10-53-910621

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 110 11

1 PLACE OF DEATH: Worcester (County) — Westborough (City or Town) — Westborough (City or town making return)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Abbie Spaulding (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. East Main St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 10 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 3, (Day) 1954 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 24, 1954, to June 3, 1954

I last saw her alive on June 3, 1954, death is said to have occurred on the date stated above, at 4:30 P m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6/2/54

ANTECEDENT CAUSES Due To (b) General Arterio-sclerosis — Years

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations.....

Date of operation..... Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? .....

If so, specify.....

(Signed) Adolf Berl M. D.

(Address) Westboro, Mass. Date 6/4/ 1954

6 Rural Cremation Worcester
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 7, 1954

7 NAME OF FUNERAL DIRECTOR William M. Tighe

ADDRESS 3 Windsor St., Marlboro

Received and filed July 7 1954

Ruth E. Reilly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

10a If married, widowed, or divorced
HUSBAND of..... (Give maiden name of wife in full)
(or) WIFE of..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Secretary (Retired) (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Fitchburg, Mass.

PARENTS

17 NAME OF FATHER Elijah Gibbs Spaulding

18 BIRTHPLACE OF FATHER (City) (State or country) Fitchburg, Mass.

19 MAIDEN NAME OF MOTHER Harriet Uihing

20 BIRTHPLACE OF MOTHER (City) (State or country) Portland, Maine

21 Informant (Address) Westborough State Hospital Records

A TRUE COPY
ATTEST: Annie A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED June 9, 1954

FORM R-301

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 12

1 PLACE OF DEATH: WORCESTER (County) — SOUTHBORO (City or Town)

No. TURN PIKE, RD. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME CHARLES FANTONY
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. TURN PIKE RD St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 40 years ..... months ..... days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 18 (Day) 1954 (Year)

4 I HEREBY CERTIFY, That I attended deceased from October 22, 1949, to June 18, 1954

I last saw him alive on June 13, 1954, death is said to have occurred on the date stated above, at 3 55 a. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Coronary Thrombosis	1½ hrs.
ANTECEDENT CAUSES Due To (b) Arteriosclerosis	5 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Polyneuritis GUILLAIN-BARRE POLYNEURITIS SYNDROME	8 months

Major findings:
Of operations: none

Date of operation: — Was autopsy performed? No

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) Timothy P. Stone, M. D.
(Address) MAIN ST., SOUTHBORO Date 6-18 1954

6 RURAL CEMETERY SOUTHBORO MASS
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 21 1954

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St Southboro, Mass

Received and filed June 19, 1954

Beatrice [illegible]
(Registrar)

A TRUE COPY ATTEST:

50M (A)-1-51 903586

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
MALE	WHITE	married

10a If married, widowed, or divorced HUSBAND of MARY E MITCHEL
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years 10 Months 26 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: RETIRED
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. 019-10 7318

16 BIRTHPLACE (City) ISPRA (State or country) ITALY

PARENTS

17 NAME OF FATHER ANDREA FANTONY

18 BIRTHPLACE OF FATHER (City) ISPRA (State or country) ITALY

19 MAIDEN NAME OF MOTHER ENRICETTA BINDA

20 BIRTHPLACE OF MOTHER (City) ISPRA (State or country) ITALY.

21 Informant MRS. MARY (MITCHEL) FANTONY
(Address) TURNPIKE, RD BAYVILLE MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of Health, JUN 18 1954
(Official Designation) (Date of Issue of Permit)

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 13

PLACE OF DEATH

1 WORCESTER (County)

SOUTHBORO (City or Town)

No. TURNPIKE RD St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME WILLIAM HAMBLEN PARK
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) —

(a) Residence. No. TURNPIKE RD St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 27 years ..... months ..... days. In place of residence 27 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 19 (Day) 1954 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Mar 16, 1953, to June 19, 1954

I last saw him alive on June 19, 1954, death is said to have occurred on the date stated above, at 3:50 p.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Coronary Thrombosis	80 min
ANTECEDENT CAUSES Due To (b)	Coronary Thrombosis	5 weeks
Due To (c)	Aortic Insufficiency ?? Rheumatic Heart Disease ??	2 years
OTHER SIGNIFICANT CONDITIONS	—	

Major findings: Of operations — —

Date of operation — Was autopsy performed? No

What test confirmed diagnosis? E.C.G

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify —

(Signed) Timothy P. Stone, M. D.

(Address) MAIN ST. SOUTHBORO Date June 21 1954

6 RURAL CEMETERY, SOUTHBORO, MASS
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 22 1954

7 NAME OF FUNERAL DIRECTOR Donald C. Mathis

ADDRESS main St Southboro Mass.

Received and filed June 23 1954

Quinton E Kelly
(Registrar)

A TRUE COPY ATTEST:

50M (A)-1-51 903586

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
MALE	WHITE	married

10a If married, widowed, or divorced HUSBAND of BEATRICE L. MILLER
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 52 Years 8 Months 18 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: SHIPPER
(Kind of work done during most of working life)

14 Industry or Business: TELECHRON MFG. CO.

15 Social Security No. 014-14-9330

16 BIRTHPLACE (City) (State or country) NEWTON MASS

PARENTS

17 NAME OF FATHER ARTHUR H. PARK

18 BIRTHPLACE OF FATHER (City) NEWTON (State or country) MASS

19 MAIDEN NAME OF MOTHER HATTIE LOUISE FLEMING

20 BIRTHPLACE OF MOTHER (City) NEWTON (State or country) MASS

21 Informant MRS. BEATRICE L (MILLER) PARK
(Address) TURNPIKE RD FAYVILLE MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone,
(Signature of Agent of Board of Health or other)

Agent BOARD OF HEALTH JUN 21 1954
(Official Designation) (Date of Issue of Permit)

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12-49-900722

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 14

PLACE OF DEATH

1 (County) Worcester

(City or Town) Southboro

No. Parkerville Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Florence Myrtle Le Gay (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Parkerville Rd St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 70 years ..... months ..... days. In place of residence 70 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 20 (Day) 1954 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Natural causes. Heart disease
Presumably coronary sclerosis
(Found dead in bed)

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19 .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) S. Arden Reed, M. D.

(Address) Grafton Mass. Date 20 Jun. 19 54

7 Place of Burial, or Cremation. Rural Cemetery Southboro (City or Town)

DATE OF BURIAL 6/22/54 19 .....

8 NAME OF FUNERAL DIRECTOR Payson O. Woods

ADDRESS 15 Church St Hopkinton

Received and filed June 23 19 54

Austin E. Kelly (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female

10 COLOR OR RACE white

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) widowed

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Charles A. Legay (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 70 Years 4 Months 9 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: machine operator (Kind of work done during most of working life)

15 Industry or Business: Telecron Inc

16 Social Security No. 022-09-6872

17 BIRTHPLACE (City) (State or country) Southboro

PARENTS

18 NAME OF FATHER Paul A. Lincoln

19 BIRTHPLACE OF FATHER (City) (State or country) Littleton Mass.

20 MAIDEN NAME OF MOTHER Clara Isette

21 BIRTHPLACE OF MOTHER (City) (State or country) Denmark, Maine

22 Informant Elizabeth Bunell (Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent (Official Designation)

BOARD OF HEALTH JUN 21 1954 (Date of Issue of Permit)

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 15

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town)

No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ann T (Carey) Baker
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Middle Rd. St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 32 years ..... months ..... days. In place of residence 32 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 27, 1954
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 9/27/53 to 6/27/54

I last saw her alive on June 17, 1954 death is said to have occurred on the date stated above, at 3:30 A.M.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) METASTATIC CARCINOMA	1 1/2 yrs.
ANTECEDENT CAUSES Due To (b) PRIMARY CARCINOMA of cervix	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations Carcinoma of Cervix

Date of operation 9/30/53 Was autopsy performed? N.D.

What test confirmed diagnosis? Microscopy of Specimen

5 Was disease or injury in any way related to occupation of deceased? N.D.

If so, specify .....

(Signed) John Paul Ahearn M. D.

(Address) Southboro, Mass. Date 6/28 1954

6 RURAL CEMETERY SOUTHBORO, MASS
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 30 1954

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Mount St. Southboro, Mass.

Received and filed June 30, 1954 19.....

Austin E. Colby
(Registrar)

A TRUE COPY ATTEST: .....

50M (A)-1-51 903586

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	WHITE	married

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of FRED L BAKER
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 49 Years 6 Months 26 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: HOUSE WIFE
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) FAYVILLE
(State or country) MASS

PARENTS

17 NAME OF FATHER WILLIAM CAREY

18 BIRTHPLACE OF FATHER (City) EAST CAMBRIDGE
(State or country) MASS

19 MAIDEN NAME OF MOTHER CATHERINE SULLIVAN

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) IRELAND

21 Informant FRED L. BAKER
(Address) MIDDLE RD. SOUTHBORO MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Boone.
(Signature of Agent of Board of Health or other)

Agent, Board of Health June 29, 1954
(Official Designation) (Date of Issue of Permit)

FORM R-303 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

25M (D)-12-49-900722

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 16

PLACE OF DEATH

1 Worcester (County)
Southborough (City or Town)

No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Michael C. Peters (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. WOOD, ST. (Usual place of abode) SOUTHVILLE, MASS St. .....

(If nonresident, give city or town and State)

Length of stay: In place of death .....years.....months.....days. In place of residence 3 years 11 months 26 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 1 (Day) 1954 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Asphyxiation by drowning

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 5 PM July 1 1954

Where did Injury occur? Southborough (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Sudbury river (Specify type of place)

Manner of Injury Drowning (How did injury occur?)

Nature of Injury Asphyxiation

While at work? m Was autopsy performed? m

6 Was disease or injury in any way related to occupation of deceased? m

If so, specify .....

(Signed) Walter F. Mahoney M. D.

(A dress) Westborough Mass Date July 1 1954

7 RURAL CEMETERY SOUTHBOROUGH (Place of Burial, or Cremation) (City or Town)

DATE OF BURIAL JULY 3 1954

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St Southboro Mass

Received and filed July 6 1954

Austin E. Keefe (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX M

10 COLOR OR RACE WHITE

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Single

11a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 3 Years 11 Months 26 Days | If under 24 hours .....Hours.....Minutes

14 Usual Occupation: ..... (Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. .....

17 BIRTHPLACE (City) (State or country) FRAMINGHAM MASS

PARENTS

18 NAME OF FATHER RAYMOND PETERS

19 BIRTHPLACE OF FATHER (City) WEST BERLIN (State or country) VT.

20 MAIDEN NAME OF MOTHER GERTRUDE C. SACCO

21 BIRTHPLACE OF MOTHER (City) MILLVILLE (State or country) MASS.

22 Informant RAYMOND PETERS (Address) WOOD ST SOUTHVILLE, MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Jim Thy P. Stone (Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) JUL 3 1954 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

BOSTON
(City or town making return)

Registered No. 6089 17

1 PLACE OF DEATH: SUFFOLK / BOSTON (County); (City or Town)

No. Mass Osteopathic Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME DAISY A HAYWOOD
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Main Street, St. Southboro, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 7 years 5 months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH (Month) July (Day) 11 (Year) 1954

4 I HEREBY CERTIFY, That I attended deceased from 7/4, 19, to 7/11, 19 54

I last saw h or alive on 7/11, 19 54 death is said to have occurred on the date stated above, at 6:15 p. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) carcinomatosis	10mos
ANTECEDENT CAUSES Due To (b) carcinoma of left breast	4yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS path. fracture of left humerus	2mos.

Major findings: Of operations: spont. fracture of rt. hip-7mos

Date of operation 1950 Was autopsy performed? no

What test confirmed diagnosis? path report-x-ray

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) H L Bess D O, M. D.

(Address) M O H Date 7/11 54

6 Fernwood Cem Lansdowne, Penn.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jul 14 54

7 NAME OF FUNERAL DIRECTOR Eastman Funeral Service

ADDRESS Boston

Received and filed July 24 54

Chester E Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	W	Single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years 9 Months 24 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: - - - (Kind of work done during most of working life)

14 Industry or Business: - - -

15 Social Security No. - - -

16 BIRTHPLACE (City) (State or country) Bostn, Mass

PARENTS

17 NAME OF FATHER William F Haywood

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER Addie Potter

20 BIRTHPLACE OF MOTHER (City) (State or country) -cannot be obtained-

21 Informant (Address) Mrs A Wilbur - cousin

A TRUE COPY

ATTEST: Chester E Kelly
(Registrar of City or Town where death occurred)

DATE FILED Jul 15 54

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return) .....

Registered No. 18

1 PLACE OF DEATH: Worcester (County) — Fayville (City or Town) — No. Oak Hill Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George Dexter Sadmenter (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Oak Hill Rd. St. ..... (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 32 years ..... months ..... days. In place of residence 32 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: July (Month) 12 (Day) 1954 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 1, 1944, to July 12, 1954. I last saw him alive on July 12, 1954, death is said to have occurred on the date stated above, at 8.55 P m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Cancer - abdominal involving intestines and bladder	2 yrs +
ANTECEDENT CAUSES Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Cystitis chronic	10 yr +

Major findings: Of operations: Perforation - by instrument

Date of operation 1954 Was autopsy performed? No

What test confirmed diagnosis? Physical exam., Clinical Course

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Roland S Winslow, M. D.

(Address) West Town Date July 12 1954

6 Edgell Grove Cem. Worcester
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 14 1954

7 NAME OF FUNERAL DIRECTOR Leonard D Caldwell

ADDRESS 21 Cottage Ave. Worcester

Received and filed July 16 1954

Christine E Kelly
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
M	White	Married

10a If married, widowed, or divorced HUSBAND of Daisy Knight Sadmenter (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years 0 Months 4 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Shoetone (Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) Attleboro (State or country) Mass.

PARENTS

17 NAME OF FATHER Edward Sadmenter

18 BIRTHPLACE OF FATHER (City) Attleboro (State or country) Mass.

19 MAIDEN NAME OF MOTHER Cannot be learned

20 BIRTHPLACE OF MOTHER (City) Cannot be learned (State or country)

21 Informant Mrs. George Sadmenter (Address) Oak Hill Rd. Fayville Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of Health.
(Official Designation)

JUL 13 1954
(Date of Issue of Permit)

50M-10-53-910621

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(c)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH
(City or town making return)

Registered No. 131 19

PLACE OF DEATH
1 MIDDLESEX (County)
MARLBOROUGH (City or Town)
No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Delia Eccles
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)
(a) Residence. No. o Main St St. Southboro, Mass
(Usual place of abode) (If nonresident, give city or town and State)
Length of stay: In place of death ..... years ..... months 10 days. In place of residence 3 years 6 months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 13, 1954
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 16 48 to July 13, 54
I last saw her alive on July 13, 1954 and death is said to have occurred on the date stated above, at 9.30 P. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Bronchopneumonia	10 dy
ANTECEDENT CAUSES Due To (b) Chronic bronchitis	20 yr
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Arteriosclerosis cerebral & cardiac	20 yr

Major findings: Of operations none
Date of operation ..... Was autopsy performed? no
What test confirmed diagnosis? X-ray

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Timothy P. Stone M. D.
(Address) Southboro Date 7-14-54 19

St. Bernard's Concord
Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 16, 1954 19

7 NAME OF FUNERAL DIRECTOR Joseph Dee '
ADDRESS Concord, Mas

Received and filed Aug 12, 1954
Curtis E. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
F	W	Widow

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of James Eccles
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: housewife
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Ireland

PARENTS

17 NAME OF FATHER John O'Toole

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Bridget Ridge

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant John Prendergast
(Address) Concord, Mass

A TRUE COPY
ATTEST: Ronald D. Lovell
(Registrar of City or Town where death occurred)
DATE FILED July 22, 1954 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

WORCESTER (City or town making return)

Registered No. 20

1 PLACE OF DEATH: WORCESTER (County); WORCESTER (City or Town)

No. Worc State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Reginald Merrills (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. - Learned St. St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 21 years 8 months 18 days. In place of residence 28 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 10 1954 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1932, to Aug 10, 1954

I last saw him alive on Aug 10, 1954, death is said to have occurred on the date stated above, at 6:45p m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a)	cerebral hemorrhage	dys
ANTECEDENT CAUSES Due To (b)	hypertensive and arteriosclerotic heart disease	yrs
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations.....
Date of operation..... Was autopsy performed? yes
What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) Jerrold P Commans, M. D.
(Address) Worc State Hosp Date Aug 10 1954

6 Place of Burial or Cremation Main St. Cem. Hudson (City or Town)
DATE OF BURIAL Aug 13 1954

7 NAME OF FUNERAL DIRECTOR Richard P Coldwell
ADDRESS Marlboro

Received and filed Sept-14 1954
Owsley E Keay
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	married

10a If married, widowed, or divorced
HUSBAND of Lydia Dutton (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 64 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: shoe worker (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) West Hartlepool (State or country) England

PARENTS

17 NAME OF FATHER Joseph Merrills

18 BIRTHPLACE OF FATHER (City) ..... (State or country) England

19 MAIDEN NAME OF MOTHER (cannot be learned)

20 BIRTHPLACE OF MOTHER (City) (cannot be learned) (State or country)

21 Informant Mrs. Lydia D Merrills
(Address) Southboro

A TRUE COPY
ATTEST: Robert J. O'Keefe
(Registrar of City of Town where death occurred)
Aug 12 1954
DATE FILED ..... 19.....

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

1 PLACE OF DEATH: SUFFOLK BOSTON (County) ..... (City or Town) .....

BOSTON (City or town making return)

Registered No. 7054 21

No. Boston City Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Peter Aspesi (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. ..... (Usual place of abode) Turnpike Rd St. Fayville Mass (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 3 months ..... days. In place of residence 29 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH ..... (Month) Aug 15, (Day) 1954 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 11, 1954, to Aug 15, 1954

I last saw h. xxx alive on xxxxxxxxxx, 19 .., death is said to have occurred on the date stated above, at 9:50 P m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a)	Encephalomalacia of right parietal lobe	days
ANTECEDENT CAUSES (b) Due To	Old Surgical cicatrix over right temporal lobe	wks
(c) Due To		
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations Removal of rt. temporal subcortical clot

Date of operation 5/12/54 Was autopsy performed? .....

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) ....., M. D.

(Address) I Merlis Date 8/16 19 54

6 Place of Burial or Cremation Rural Cem. (City or Town) Southboro Mass

DATE OF BURIAL Aug 19 19 54

7 NAME OF FUNERAL DIRECTOR J L Norton & Son

ADDRESS Framingham Mass

Received and filed Aug 18 19 54

Curtin & Kelly Dep. Clk.

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced
HUSBAND of Rosa Bianchi (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 55 Years 8 Months 8 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Mason (Kind of work done during most of working life)

14 Industry or Business: Landscape

15 Social Security No. 024-10-0388

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Charles Aspesi

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Teresa Columbo

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant (Address) Wife

A TRUE COPY
ATTEST: Charles A. Mackie
(Registrar of City or Town where death occurred)

DATE FILED Aug 18 19 54

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 22

1 PLACE OF DEATH

Middlesex (County)

Framingham (City or Town)

No. Framingham Union Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME baby boy Davis (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Main St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 30, 1954 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....

I last saw h.....alive on Stillborn, 19....., death is said to have occurred on the date stated above, at 5 p.....m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Prematurity 6 mos gest. Circum vallate placenta

ANTECEDENT CAUSES (b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS Circum vallate placenta

Major findings:
Of operations.....

Date of operation.....Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....

(Signed) Joseph C. Merriam M. D.

(Address) Framingham Date 10/30/54

6 Edgell Grove, Framingham
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 11/1/54 19....

7 NAME OF FUNERAL DIRECTOR R. K. Wadsworth

ADDRESS Framingham

Received and filed Nov 1 1954

Custis E. Kelly Town Clerk.
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here. STILLBORN

12 AGE.....Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation:.....
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Framingham
(State or country) Mass.

PARENTS

17 NAME OF FATHER Walter M. Davis

18 BIRTHPLACE OF FATHER (City) Southboro
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Betty Jane Sayles

20 BIRTHPLACE OF MOTHER (City) Binghamton
(State or country) N Y.

21 Informant.....
(Address) Southboro

A TRUE COPY
ATTEST: Wm. E. Walsh
(Registrar of City or Town where death occurred)

DATE FILED Nov. 1, 1954

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-(B)-11-51-905807

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Hudson (City or town making return)

Registered No. 23

1 PLACE OF DEATH: Middlesex (County); Hudson (City or Town)

No. 26 Causeway St., Hudson St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lottie (Hollis) Fairbanks (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Cordaville Road, Southville St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death 1 years ..... months ..... days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 26, (Day) 1954 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1954, to Nov. 26, 1954

I last saw her alive on Nov. 26, 1954, death is said to have occurred on the date stated above, at 11:10 A.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Coronary occlusion	8 hrs
ANTECEDENT CAUSES Due To (b) Arteriosclerosis	years
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations no operation

Date of operation ..... Was autopsy performed? .....

What test confirmed diagnosis? Examinations

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) C. W. Smith, M. D.

(Address) Marlboro, Mass. Date 11-27-1954

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 28, 1954

7 NAME OF FUNERAL DIRECTOR Richard P. Coldwell

ADDRESS 21 Cotting Ave., Marlboro

Received and filed Jan 4, 1955

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Hollis Henry Fairbanks (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 89 Years 1 Months 6 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Upton, Mass.

PARENTS

17 NAME OF FATHER Cannot be learned

18 BIRTHPLACE OF FATHER (City) Cannot be learned (State or country)

19 MAIDEN NAME OF MOTHER Cannot be learned

20 BIRTHPLACE OF MOTHER (City) Cannot be learned (State or country)

21 Informant Mrs. Henry H. Reddy
(Address) 26 Causeway St., Hudson

A TRUE COPY
ATTEST: G. Woodbury Parker
(Registrar of City or Town where death occurred)

DATE FILED 12-20-54

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 24

1 PLACE OF DEATH

Middlesex (County)

Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Girl Dyer
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. White Bagley Road St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.
20 minutes

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 10, 1954
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1954, to Dec. 10, 1954

I last saw her alive on Dec. 10, 1954 death is said to have occurred on the date stated above, at .....m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Erythroblastosis

ANTECEDENT CAUSES Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Prematurity

Major findings:
Of operations.....

Date of operation.....Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....

(Signed) Thomas Paull, M. D.

(Address) Framingham, Mass. Date Dec. 10, 1954

6 Wilwood Cemetery Ashland, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 13, 1954 19

7 NAME OF FUNERAL DIRECTOR Robert K. Wadsworth

ADDRESS 108 Lincoln St. Framingham

Received and filed Dec. 15, 1954 19

Austin E. Kelley, Town Clerk
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Fem.	White	Single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE .....Years.....Months.....Days If under 24 hours .....Hours 20 Minutes

13 Usual Occupation: None
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No. None

16 BIRTHPLACE (City) Framingham, Mass.
(State or country)

PARENTS

17 NAME OF FATHER Ralph Leroy Dyer

18 BIRTHPLACE OF FATHER (City) Hanover,
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Florence Marion Spinazzola

20 BIRTHPLACE OF MOTHER (City) Framingham
(State or country) Mass.

21 Informant Ralph L. Dyer, Father
(Address) Southboro, Mass.

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED Dec. 13, 1954 19

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 25

1 PLACE OF DEATH: Worcester (County) — Southborough (City or Town) — No. Southville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Avera (Reynolds) Nelson
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) 2

(a) Residence. No. Southville Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 32 years ..... months ..... days. In place of residence 32 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 25, 1954 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from October, 1954, to December, 1954

I last saw her alive on Dec 24, 1954, death is said to have occurred on the date stated above, at 12:30 A.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) uremia	1 week
ANTECEDENT CAUSES Due To (b) metastatic carcinoma primary unknown	3 months
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings:
Of operations

Date of operation ..... Was autopsy performed? No

What test confirmed diagnosis? X ray examination

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Marilyn M. Meserve, M. D.
(Address) Southboro, Mass. Date Dec. 26 1954

6 Rural Cemetery Southborough
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 27 1954

7 NAME OF FUNERAL DIRECTOR Irving W. Harper
ADDRESS 124 Main St, Westboro

Received and filed December 28 1954
Curtis L Kelley
(Registrar)
Town Clerk

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
F	White	Married

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Wallace Nelson Jr.
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 58 Years 3 Months 11 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Parsboro
(State or country) Nova Scotia

PARENTS

17 NAME OF FATHER Harry Reynolds

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Charlotte Satter

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)

21 Informant Wallace Nelson Jr.
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Board of Health Dec. 26, 1954
(Official Designation) (Date of Issue of Permit)

100M-10-53-910621

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return) .....

Registered No. 1

PLACE OF DEATH

1 (County) Worcester

(City or Town) Southboro

No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Howard P. Lane
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Middle Road (Usual place of abode) Southboro, Mass St. .....
(If nonresident, give city or town and State)

Length of stay: In place of death 40 years ..... months ..... days. In place of residence 40 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 14 (Day) 1955 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1954, to Jan 14, 1955

I last saw him alive on Jan 13, 1955, death is said to have occurred on the date stated above, at 6 P.M.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) BRONCHOPNEUMONIA	3 days
ANTECEDENT CAUSES	(b) Due To ARTERIOSCLEROTIC HEART DISEASE	4 YEARS
	(c) Due To	
OTHER SIGNIFICANT CONDITIONS	Cholecystectomy for Acute Cholecystitis	1 month

Major findings:
Of operations .....

Date of operation ..... Was autopsy performed? No

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify Marilyn Meserve
(Signed) MARILYN MESERVE, M. D.
(Address) Southboro, Mass Date Jan 15, 1955

6 Rural Cemetery (Place of Burial or Cremation) Southboro, Mass (City or Town)
DATE OF BURIAL January 16, 1955

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass

Received and filed Jan 17, 1955
Mary J. Kelly Asst Town Clerk
(Registrar)

A TRUE COPY ATTEST:

50M-10-53-910621

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE / MARRIED / WIDOWED / or DIVORCED (write the word)
Male	White	Widowed

10a If married, widowed, or divorced
HUSBAND of Katherine G. Kerr
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 89 Years 6 Months 19 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Farmer
(Kind of work done during most of working life)

14 Industry or Business: Farm Gardener

15 Social Security No. .....

16 BIRTHPLACE (City) Gloucester
(State or country) Mass

PARENTS

17 NAME OF FATHER David Lane

18 BIRTHPLACE OF FATHER (City) Gloucester
(State or country) Mass

19 MAIDEN NAME OF MOTHER Julia Lane

20 BIRTHPLACE OF MOTHER (City) Gloucester
(State or country) Mass

21 Informant (Address) Charles H. Lane Middle Road Southboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Shore
(Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) Jan 16, 1955 (Date of Issue of Permit)

FORM R-301A

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 2

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Boston Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mildred E. (Leighton) Paul
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Manley Road St. Auburn, Maine
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 76 years 9 months 28 days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

Note:- Chapter 137, Acts of 1954, requires Physicians to print or type the cause or causes of death on death certificates.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH (Month) Jan. (Day) 29, (Year) 1955

4 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1954, to Jan 29, 1955

I last saw her alive on Jan 28, 1955, death is said to have occurred on the date stated above, at 10 15 P. m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma of the Breast — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Arteriosclerosis — 4 years

Major findings: Of operation: L Mastectomy left breast

Date of operation 1950 Was autopsy performed? no

What test confirmed diagnosis? Biopsy

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Mildred M. Hatton M. D.

(Address) Jan 31, 1955 Southboro, Mass.

6 Mt. Auburn Cem., Auburn, Maine
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 1, 1955

7 NAME OF FUNERAL DIRECTOR C. Ronald Merriam

ADDRESS Framingham, Mass.

Received and filed Feb. 1 1955

Austin E. Kelly (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Oliver Frank Paul
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years 9 Months 28 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Sticher
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 006-24-0788

16 BIRTHPLACE (City) (State or country) Auburn Maine

PARENTS

17 NAME OF FATHER Alva Leighton

18 BIRTHPLACE OF FATHER (City) (State or country) Auburn Maine

19 MAIDEN NAME OF MOTHER Delores Moore

20 BIRTHPLACE OF MOTHER (City) (State or country) Auburn Maine

21 Informant Mrs. Evelyn Houghton
(Address) Boston Rd., Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of H. (Official Designation) 1/31/55 (Date of Issue of Permit)

50M-3-54-911887

FORM R-303

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-10-53-910621

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 3

1 PLACE OF DEATH
Worcester (County)
Fitchburg (City or Town)
No. Oak Hill Rd. St. Fitchburg (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Wheelock Clem Burgess
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Oak Hill Rd. St. Fitchburg
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 5 months ..... days. In place of residence 1 years 5 months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. (Month) 3 (Day) 1955 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Natural Causes: Heart Disease
presumably Coronary occlusion
(Sudden Death)

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) S. Dean Jones M. D.

(Address) Ayer, Mass. Date Feb 3 19 55

7 Westwood Cem. Marlboro
Place of Burial, or Cremation (City or Town)

DATE OF BURIAL Feb 5 19 55

8 NAME OF FUNERAL DIRECTOR Richard P. Caldwell

ADDRESS 21 Cutting Ave Marlboro

Received and filed Feb 4 19 55

Geo. E. Reedy (Registrar)

A TRUE COPY ATTEST: .....

PERSONAL AND STATISTICAL PARTICULARS

9 SEX M

10 COLOR OR RACE White

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

11a If married, widowed, or divorced HUSBAND of Emma Louise Henderson
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 77 Years 4 Months 3 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Farming
(Kind of work done during most of working life)

15 Industry or Business: Retired Husband Unsalaried

16 Social Security No. 025-16-3450

17 BIRTHPLACE (City) (State or country) Windsor Nova Scotia

PARENTS

18 NAME OF FATHER John Burgess

19 BIRTHPLACE OF FATHER (City) (State or country) Nova Scotia

20 MAIDEN NAME OF MOTHER Ellen Baxter

21 BIRTHPLACE OF MOTHER (City) (State or country) Scotland

22 Informant Mrs. Robert F. Willard
(Address) Oak Hill Rd. Fitchburg, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Shone.
(Signature of Agent of Board of Health or other)

Agent, Board of Health Feb 3, 1955
(Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

4

MARLBOROUGH
(City or town making return)

27
Registered No.

1 PLACE OF DEATH

MIDDLESEX
(County)

MARLBOROUGH
(City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles F. Palmer
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Woodbury Road St. Cordaville, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence 26 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 12, 1955
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1955, 19..., to Feb 12, 1955, 19...

I last saw him alive on ..., 19..., death is said to have occurred on the date stated above, at ... m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Coronary thrombosis 1 dy — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES (b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations

Date of operation ... Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) R. A. Johnson M. D.

(Address) Marlborough Date 2-12-55, 19...

6 Newton Crematory Newton, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb 14, 1955, 19...

7 NAME OF FUNERAL DIRECTOR Robert K. Wadsworth
Framingham, Mass

ADDRESS

Received and filed Feb 14, 1955, 19...
March 10, 1955

(Registrar of City or Town where deceased resided)

Town Copy.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	W	MARRIED

10a If married, widowed or divorced HUSBAND of Grace I Day
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 54 Years 6 Months 11 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Linotype operator
(Kind of work done during most of working life)

14 Industry or Business: Herald-Traveler

15 Social Security No. 027-10-8088

16 BIRTHPLACE (City) Scotland
(State or country)

PARENTS

17 NAME OF FATHER James Palmer

18 BIRTHPLACE OF FATHER (City) Scotland
(State or country)

19 MAIDEN NAME OF MOTHER Mary Coutts

20 BIRTHPLACE OF MOTHER (City) Scotland
(State or country)

21 Informant Mrs. Grace I Palmer
(Address)

A TRUE COPY.
ATTEST: Raymond D. Lovell
(Registrar of City or Town where death occurred)

DATE FILED Feb 14, 1955, 19...

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E).6-50.902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH 5
(City or town making return)

Registered No. 28

1 PLACE OF DEATH

MIDDLESEX
(County)

MARLBOROUGH
(City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jay Alan Foss
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Main Street Southboro, St. Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 13, 1955
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1955, to Feb 13 1955

I last saw him alive on Feb 13, 1955, death is said to have occurred on the date stated above, at 7.32 P. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Pneumnitis right and left	2 dy
ANTECEDENT CAUSES Due To (b) Aspiration	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS none	

Major findings: Of operations none

Date of operation none Was autopsy performed? no

What test confirmed diagnosis? phy exam

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.

(Signed) Arthur G. Simoneau M. D.

(Address) Marlborough, Mass Date 2-14-55

6 Bay View Gouldsboro, Me
Place of Burial or Cremation (City or Town)
entombed.

DATE OF BURIAL 19

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass

Received and filed March 1, 1955

Thos E Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
M	W	single

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE ..... Years 6 Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: ..... (Kind of work done during most of working life)

14 Industry or Business: ..... /

15 Social Security No. .....

16 BIRTHPLACE (City) Marlborough, Mass
(State or country)

PARENTS

17 NAME OF FATHER Elliott L. Foss

18 BIRTHPLACE OF FATHER (City) Gouldsboro, Me
(State or country)

19 MAIDEN NAME OF MOTHER Gladys Brockhouse

20 BIRTHPLACE OF MOTHER (City) Boston, Mass
(State or country)

21 Informant Elliott L. Foss
(Address)

A TRUE COPY
ATTEST: Raymond D. Lavallee
(Registrar of City or Town where death occurred)

DATE FILED Feb 14, 1955 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham 6
(City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County) — Framingham (City or Town) — No. Framingham Union Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: baby boy LaBarre
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Main St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death .....years .....months 2 days. In place of residence .....years .....months .....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Feb. 22, 1955
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1955, to Feb. 22, 1955

I last saw him alive on Feb. 21, 1955, death is said to have occurred on the date stated above, at 5.45A m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Atelectasis	
ANTECEDENT CAUSES Due To (b) prematurity	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings:
Of operations .....
Date of operation ..... Was autopsy performed? no
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Thomas Daull M. D.
(Address) Framingham Date 2/22/55

6 Rural Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Feb. 23, 1955

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Southboro

Received and filed March 2, 1955
Carolyn E. Kelly
(Registrar of City or Town where deceased resided)
Town Clerk

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	single

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE .....Years .....Months 2 .....Days | If under 24 hours .....Hours .....Minutes

13 Usual Occupation: .....
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) Framingham
(State or country) Mass

PARENTS

17 NAME OF FATHER Richard F. LaBarre

18 BIRTHPLACE OF FATHER (City) Marlboro
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Mary M. McGarry

20 BIRTHPLACE OF MOTHER (City) Woburn
(State or country) Mass.

21 Informant Richard F. LaBarre
(Address) Southboro

A TRUE COPY
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED March 3, 1955

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(h)-10-48-24658

4

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Taunton (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Bristol (County); Taunton (City or Town); No. Myles Standish State School St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Anthony Ferrecchia (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) ---

(a) Residence. No. School St. St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death -- years -- months 5 days. In place of residence 2 years 9 months 8 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 28, (Day) 1955 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Measles with Pneumonia

Mongolism

5 Accident, suicide, or homicide (specify) ---

Date and hour of injury ---- 19....

Where did Injury occur? ---- (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ---- (Specify type of place)

Manner of Injury None (How did injury occur?)

Nature of Injury None

While at work? No Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify ---

(Signed) Andrew J. Leddy, M. D.

(Address) 233 Bay St. Date 2/28 19 55

7 Immaculate Conception Marlboro (Place of Burial, or Cremation.) (City or Town)

DATE OF BURIAL March 1, 19 55

8 NAME OF FUNERAL DIRECTOR John P. Rowe

ADDRESS 57 Main St., Marlboro, Mass.

Received and filed March 2, 1955

Curtis E. Kelly Townclerk

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

11a If married, widowed, or divorced
HUSBAND of --- (Give maiden name of wife in full)
(or) WIFE of --- (Husband's name in full)

12 IF STILLBORN, enter that fact here. -----

13 AGE 2 Years 9 Months 8 Days | If under 24 hours ---Hours ---Minutes

14 Usual Occupation: None (Kind of work done during most of working life)

15 Industry or Business: ----

16 Social Security No. ----

17 BIRTHPLACE (City) Sonthofen (State or country) Germany

PARENTS

18 NAME OF FATHER Joseph Anthony Ferrecchia

19 BIRTHPLACE OF FATHER (City) Marlboro, Mass. (State or country)

20 MAIDEN NAME OF MOTHER Martha Clematis Thomas

21 BIRTHPLACE OF MOTHER (City) Hudson, Mass. (State or country)

22 Informant Myles Standish State School
(Address) Box 631, Taunton, Mass.

A TRUE COPY.
ATTEST: Henry P. Gallivan
(Registrar of City or Town where death occurred)

DATE FILED March 2, 19 55

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-1-52-906135

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 8

PLACE OF DEATH

1 Worcester (County)
Southborough (City or Town)
No. Prentice St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edward C. Ramsdell
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Printers St. Southville
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 37 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 15 (Day) 1955 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronon Sclerosis

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury ..... 19 .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury ..... (How did injury occur?)
Nature of Injury .....
While at work? nr Was autopsy performed? nr

6 Was disease or injury in any way related to occupation of deceased? nr
If so, specify .....
(Signed) Walter F Mahoney M. D.
(Address) Westborough Mass Date 3-15 1955

7 Burial, Cremation, or Removal Worcester (City or Town)
DATE OF BURIAL Mar 17 1955

8 NAME OF FUNERAL DIRECTOR [illegible]
ADDRESS [illegible]

Received and filed March 17 1955
Austin E Kelly (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male

10 COLOR OR RACE White

11 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word) *

11a If married, widowed, or divorced HUSBAND of Jennie L. Hansmond (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 88 Years 7 Months 1 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Lawyer (Kind of work done during most of working life)

15 Industry or Business: Retired

16 Social Security No. .....

17 BIRTHPLACE (City) Natick (State or country) Mass

PARENTS

18 NAME OF FATHER Stillman S. Ramsdell

19 BIRTHPLACE OF FATHER (City) Natick, Mass. (State or country) Mass.

20 MAIDEN NAME OF MOTHER Mary E. Perry

21 BIRTHPLACE OF MOTHER (City) Can not beleanned (State or country)

22 Informant Miss. Violet Ramsdell
(Address) Prentice St, Southville, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone.
(Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) March 16, 1955 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-(D)-11-51-905807

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

11

Marlborough (City or town making return)

Registered No. 67

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town)

No. Marlborough Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ralph Waldo Milliken (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran; if so specify WAR) No

(a) Residence. No. Walker St. (Usual place of abode) Southboro, Mass (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 11 days. In place of residence 5 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 7 (Day) 1955 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 2 55, to April 7 55

I last saw him alive on April 6, 55, death is said to have occurred on the date stated above, at ..... m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Cerebral Hemorrhage	9 das.
ANTECEDENT CAUSES (b) Due To	Hypertensive	10 yrs.
	Arteriosclerotic disease	
(c) Due To	Arteriosclerosis	15 yrs.
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations.....

Date of operation..... Was autopsy performed? No

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) William J. Betinis M. D.

(Address) Marlboro, Mass. Date: 4/7, 19 55

6 Ridgelawn
Place of Burial or Cremation (City or Town)

DATE OF BURIAL ..... 19....

7 NAME OF FUNERAL DIRECTOR Norman P. Robinson

ADDRESS 809 Main St. Melrose, Mass.

Received and filed JUNE 4, 1955

Curtis E. Holt Registrar

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced HUSBAND of Anna E. Connors (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years 10 Months 30 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired (Kind of work done during most of working life)

14 Industry or Business: Railroad conductor

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Ellsworth, Maine

PARENTS

17 NAME OF FATHER Maynard Milliken

18 BIRTHPLACE OF FATHER (City) Mt. Desert Island (State or country) Maine

19 MAIDEN NAME OF MOTHER Charlotte Reed

20 BIRTHPLACE OF MOTHER (City) Unknown (State or country) Maine

21 Informant (Address) Mrs. Ruth M. Payson (daughter) 7 Sheffield Rd., Melrose, Mass.

A TRUE COPY

ATTEST: Raymond D. Lowell (Registrar of City or Town where death occurred)

J. Alberic Boudreau

DATE FILED ..... 19.... April 8, 1955

9

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-5-52-907046

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. ....

1 PLACE OF DEATH
Worcester (County)
Westborough (City or Town)
No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Catherine D. Logan (If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) ....

(a) Residence. No. (Usual place of abode) St. Mark's School St. Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death -- years 10 months 21 days. In place of residence .... years .... months .... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 26, (Day) 1955 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Arteriosclerotic Heart Disease
Fractured Hip

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury January 17, 1955
Where did Injury occur? Westborough, Mass. (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Westborough State Hospital (Specify type of place)
Manner of Injury Unknown (How did injury occur?)
Nature of Injury Fractured Hip
While at work? No Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No
If so, specify ....
(Signed) Walter F. Mahoney, M. D.
(Address) Westboro, Mass. Date 4/26. 1955

7 Center Cem. Branford, Conn.
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL April 28, 1955

8 NAME OF FUNERAL DIRECTOR Richard P. Caldwell
ADDRESS Marlborough, Mass.

Received and filed May 9, 1955
Cora Ann E Kelly Town clerk
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female

10 COLOR OR RACE White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) Widowed

11a If married, widowed, or divorced
HUSBAND of .... (Give maiden name of wife in full)
(or) WIFE of James E. Logan (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 88 Years .... Months .... Days .... If under 24 hours .... Hours .... Minutes

14 Usual Occupation: Housewife (Kind of work done during most of working life)

15 Industry or Business: ....

16 Social Security No. ....

17 BIRTHPLACE (City) Springhill, (State or country) Scotland

PARENTS

18 NAME OF FATHER Alexander Dingwall

19 BIRTHPLACE OF FATHER (City) (State or country) Scotland

20 MAIDEN NAME OF MOTHER Catherine Denoon

21 BIRTHPLACE OF MOTHER (City) (State or country) Scotland

22 Informant (Address) Westborough State Hospital Records

A TRUE COPY.
ATTEST: Annie A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED May 2, 1955

FORM R-301

10

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return) .....

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. 14 Woodland Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Arthur David Monroe (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. 14 Woodland Road St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 5 years ..... months ..... days. In place of residence 5 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 20, (Day) 1955 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 23, 1954 to May 20, 1955

I last saw him alive on May 20, 1955, death is said to have occurred on the date stated above, at 11:45 A.M.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Coronary occlusion	45 Mins
ANTECEDENT CAUSES Due To (b)	Coronary Artery disease.	?
Due To (c)	//	
OTHER SIGNIFICANT CONDITIONS	Recurrent Pyeloneph-ritis.	20yrs Dur.

Major findings: Of operations none.

Date of operation // Was autopsy performed? no

What test confirmed diagnosis? none.

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Donald E. Love M. D.

(Address) 118 Union Ave. Date 5-21 1955

6 Rural Crematory Worcester Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 22 1955

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass

Received and filed May 24. 1955

Austin E. Kelly, Town Clerk.
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced HUSBAND of Helen Emma Urquhart (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 41 Years 8 Months 25 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Machinist (Kind of work done during most of working life)

14 Industry or Business: Dorrington Mfg Co Inc

15 Social Security No. 034-09-4976

16 BIRTHPLACE (City) Boston (State or country) Mass

PARENTS

17 NAME OF FATHER could not be learned

18 BIRTHPLACE OF FATHER (City) could not be learned (State or country)

19 MAIDEN NAME OF MOTHER could not be learned

20 BIRTHPLACE OF MOTHER (City) could not be learned (State or country)

21 Informant Mrs. Helen (Urquhart) Monroe (Address) 14 Woodland Rd Southboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone.
(Signature of Agent of Board of Health or other)

Agent Bd of Health 5/22/55
(Official Designation) (Date of Issue of Permit)

50M-10-53-910621

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-10-53-910621

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

BOSTON 12
(City or town making return)

Registered No. 6076

1 PLACE OF DEATH: SUFFOLK / BOSTON (County); (City or Town)

No. 265 Neponset Ave. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME JOHN L GEARY (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 3 Cottage St. (Cordaville) Southboro, Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 3 days. In place of residence 15 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 26 (Day) 1955 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6/3, 19..., to 6/22, 1955

I last saw him alive on 6/21, 1955, death is said to have occurred on the date stated above, at ... m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Pulmonary edema	5days
ANTECEDENT CAUSES Due To (b) Chronic myocarditis-?	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Arteriosclerotic disease, generalized	

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) J Annunziata, M. D.

(Address) Hopkinton, Mass Date 6/27, 1955

6 Mt. Benedict (Place of Burial or Cremation) W Rox, Mass (City or Town)

DATE OF BURIAL Jun 29, 1955

7 NAME OF FUNERAL DIRECTOR T Callanan

ADDRESS Hopkinton, Mass

Received and filed Aug 10, 1955, 19...

Austin J. Kelly T.C.
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	W	Widowed

10a If married, widowed, or divorced HUSBAND of Margaret Kelley (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years ..... Months 2 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Farmer (Kind of work done during most of working life)

14 Industry or Business: - - -

15 Social Security No. 016-22-7014

16 BIRTHPLACE (City) Lincoln (State or country) Vt

PARENTS

17 NAME OF FATHER Daniel Geary

18 BIRTHPLACE OF FATHER (City) ..... (State or country) USA

19 MAIDEN NAME OF MOTHER Mary Halnon

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Ireland

21 Informant Mrs Margaret Hurstak (Address)

A TRUE COPY
ATTEST: Charles H. Mackie
(Registrar of City or Town where death occurred)

DATE FILED Jun 29, 1955

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-10-53-910621

13

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town); Westborough (City or town making return)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Fannie Louise Clark (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Rd. (Usual place of abode) St. Southville, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 10 months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 14, (Day) 1955 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 1, 1955, to Aug. 14, 1955

I last saw her alive on Aug. 11, 1955, death is said to have occurred on the date stated above, at 2:30 p.m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Chronic Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: unk

ANTECEDENT CAUSES Due To (b) Generalized Arteriosclerosis — yrs

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS .....

Major findings: Of operations .....

Date of operation ..... Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Aladar Schoenfeld, M. D.

(Address) Westboro, Mass. Date 8/14/ 55

6 Rural Cemetery, Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 17, 55

7 NAME OF FUNERAL DIRECTOR Frederic A. Gibbs

ADDRESS Wayland, Mass.

Received and filed Sept 2, 1955

Austin J. Reilly, Town Clerk. (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Howard S. Clark (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 90 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) East Brookfield, Mass.

PARENTS

17 NAME OF FATHER Solon Aikens

18 BIRTHPLACE OF FATHER (City) Barnard, (State or country) Vermont

19 MAIDEN NAME OF MOTHER Fannie Scully

20 BIRTHPLACE OF MOTHER (City) Barnard, (State or country) Vermont

21 Informant (Address) Westborough State Hospital Records

A TRUE COPY
ATTEST: Annie A. Dunne (Registrar of City or Town where death occurred)

DATE FILED August 22, 1955

14

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. .....

1 PLACE OF DEATH

Md Middlesex
(County)

Framingham
(City or Town)

No. Framingham Union Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME baby girl Lambert
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Richards Rd. St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death .....years .....months 2 days. In place of residence .....years .....months .....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 14, 1955
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 12 1955, to Sept. 14, 1955

I last saw her alive on Sept. 14 1955, death is said to have occurred on the date stated above, at 6.31A m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Prematurity & atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 6m3wks

ANTECEDENT CAUSES Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) Jean C. Avery M. D.
(Address) Framingham Date 9/14/55

6 Rural Cem., Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Sept. 14, 1955 19

7 NAME OF FUNERAL DIRECTOR R.P.Coldwell
ADDRESS Marlboro

Received and filed Sept 19. 19 S.T.
Arthur E. Kelly, Town Clerk.
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR OR RACE: white
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE .....Years .....Months 2 Days | If under 24 hours .....Hours .....Minutes

13 Usual Occupation:.....
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Framingham
(State or country) Mass.

PARENTS

17 NAME OF FATHER Edward E. Lambert

18 BIRTHPLACE OF FATHER (City) Marlboro
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Ruth Rounsevell

20 BIRTHPLACE OF MOTHER (City) New Bedford
(State or country) Mass.

21 Informant Edward E. Lambert
(Address) Southboro

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED Sept. 15, 1955 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

15

1 PLACE OF DEATH: MIDDLESEX (County) MARLBOROUGH (City or Town) — MARLBOROUGH (City or town making return) — Registered No. 201

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ina Offutt (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Main Street, Southboro, Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH (Month) October (Day) 15, (Year) 1955

4 I HEREBY CERTIFY, That I attended deceased from Sept 29, 55, to Oct 15, 55

I last saw her alive on Oct 14, 1955, death is said to have occurred on the date stated above at 5.30 P. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Pelvic Abscess	2 wk
ANTECEDENT CAUSES Due To (b) Carcinoma of rectum	9 mos
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Metastases to liver	1 mo

Major findings: Of operations Carcinoma of rectum

Date of operation 9-6-55 Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Marilyn Meserve, M. D.

(Address) Southboro, Mass Date 10-15-55

6 Place of Burial or Cremation Southboro (City or Town)

DATE OF BURIAL Oct 18, 1955

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass

Received and filed Oct 16, 1955

Curtis E. Kelly (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	W	Married

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Walter M. Offutt (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 73 Years 11 Months 16 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Lowell, Mass

PARENTS

17 NAME OF FATHER Charles Whitten

18 BIRTHPLACE OF FATHER (City) Lowell, Mass (State or country)

19 MAIDEN NAME OF MOTHER Alice Quimby

20 BIRTHPLACE OF MOTHER (City) Center Harbor, N.H. (State or country)

21 Informant Walter M. Offutt (Address) Southboro, Mass

A TRUE COPY. Raymond D. Lavallee

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Oct 18, 1955

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-(B)-11-51-905807

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 218

1 PLACE OF DEATH: MIDDLESEX (County); MARLBOROUGH (City or Town); MARLBOROUGH (City or town making return)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ferdinand E. Bagley (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. White Bagley Road Southboro, Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 year(s) months days. In place of residence 50 year(s) 4 months 7 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov 10, 1955 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan, 54, to Nov 10, 55

I last saw him alive on Nov 10, 55, death is said to have occurred on the date stated above, at 1.34 P m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a)	Arteriosclerotic heart disease	yrs
ANTECEDENT CAUSES (b)		
Due To (c)	Congestive heart failure	mos.
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations

Date of operation Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Allen H. Knapp, M. D.

(Address) Westboro Date 11-11-55

6 Rural Southboro Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 12, 1955

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass

Received and filed Nov 15 55

Chester E Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
M	W	Single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 50 Years 4 Months 8 Days | If under 24 hours Hours Minutes

13 Usual Occupation: Steam fitter (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 021-07-3196

16 BIRTHPLACE (City) (State or country) Southboro, Mass

PARENTS

17 NAME OF FATHER Thomas H. Bagley

18 BIRTHPLACE OF FATHER (City) (State or country) Charlton, Mass

19 MAIDEN NAME OF MOTHER Mary Carrigan

20 BIRTHPLACE OF MOTHER (City) (State or country) Northboro, Mass

21 Informant (Address) Gertrude Bagley Southboro, Mass

A TRUE COPY ATTEST: Raymond D. Lavallee
(Registrar of City or Town where death occurred)

DATE FILED Nov 14, 1955

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

1 PLACE OF DEATH

Middlesex (County)

Framingham (City or Town)

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

No. Framingham Union Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Eugene Beliveau (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Central St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 22 days. In place of residence 2 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 14, 1955 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 21 19 54 to Nov. 14, 19 55

I last saw h. im alive on Nov. 13, 19 55 death is said to have occurred on the date stated above, at 7.35A m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Coronary thrombosis	5 wks
ANTE CEDENT CAUSES Due To (b) Arteriosclerosis	yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis? E C G

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Timothy P. Stone M. D.

(Address) Southboro Date 11/15/55

6 St. Johns Worcester
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 11/16/55 19

7 NAME OF FUNERAL DIRECTOR James E. Fay

ADDRESS Worcester

Received and filed Nov 18, 1955 19

Eunice E. Kelly Town Clerk
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	wid.

10a If married, widowed, or divorced HUSBAND of Joseph Sullivan (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Mechanic (Kind of work done during most of working life)

14 Industry or Business: Worcester Bus Co.

15 Social Security No. 034-09-3339A

16 BIRTHPLACE (City) Webster (State or country) Mass.

PARENTS

17 NAME OF FATHER Louis Beliveau

18 BIRTHPLACE OF FATHER (City) ..... (State or country) CNBL

19 MAIDEN NAME OF MOTHER Mathilda Rondeau

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) cnbl

21 Informant Paul A. Beliveau
(Address) Southboro

A TRUE COPY
ATTEST: Wm. A. Walsh
(Registrar of City or Town where death occurred)

DATE FILED Nov. 16, 1955 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-(B)-11-51-905807

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 28

1 PLACE OF DEATH: (County) MIDDLESEX; (City or Town) MARLBOROUGH; (City or town making return) MARLBOROUGH

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Infant Reilly (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Road (Usual place of abode) Fayville, St. Mass (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov 23, 1955 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov 23, 55, to Nov 23, 55

I last saw h... or alive on Nov 25, 55, death is said to have occurred on the date stated above, at 6.45 P. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Prematurity (5 mos)	15 min
ANTECEDENT CAUSES (b) Due To	
(c) Due To	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation.....Was autopsy performed? no

What test confirmed diagnosis? Clin

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify.....

(Signed) John J. Lepore, M. D.

(Address) Marlborough, Mass Date Nov 25, 1955

6 Place of Burial or Cremation Immaculate Conception (City or Town) Marlborough

DATE OF BURIAL Nov 26, 1955

7 NAME OF FUNERAL DIRECTOR John P Rowe

ADDRESS Marlborough, Mass

Received and filed DEC 13 1955

Curtis S Kelly

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
F	W	Single

10a If married, widowed, or divorced HUSBAND of..... (Give maiden name of wife in full)

(or) WIFE of..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE.....Years.....Months.....Days | If under 24 hours .....Hours 15 Minutes

13 Usual Occupation:..... (Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Marlborough, Mass (State or country)

PARENTS

17 NAME OF FATHER George Reilly

18 BIRTHPLACE OF FATHER (City) Newark, N.J. (State or country)

19 MAIDEN NAME OF MOTHER Madelice Holmes

20 BIRTHPLACE OF MOTHER (City) Brockton, Mass (State or country)

21 Informant..... (Address) George Reilly Fayville, Mass

A TRUE COPY ATTEST: Raymond D. Lavallee (Registrar of City or Town where death occurred)

DATE FILED ..... 19.....

FORM R-301

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

19 19

Southboro (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Lyman St St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Marjorie (Fuller) McCobb
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Lyman St St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 10 years ..... months ..... days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 30 (Day) 1955 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1955, to Nov. 30, 1955

I last saw her alive on Nov. 30, 1955, death is said to have occurred on the date stated above, at 8:45p. m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) Coronary Thrombosis	Sudden
ANTECEDENT CAUSES	Due To (b) Coronary Insufficiency	one week
	Due To (c)	
OTHER SIGNIFICANT CONDITIONS		

Major findings:
Of operations .....
Date of operation ..... Was autopsy performed? No
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) [signature] M. D.
(Address) Westboro, Mass. Date 12/2 1955

6 Rural Cemetery Southboro, Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Dec. 3, 1955 19

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main ST. Southboro, Mass

Received and filed DECEMBER 15 1955
Austin E Kelly (Registrar)
A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	White	Married

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Frederick M. McCobb (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 40 Years 10 Months 7 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Hair dresser & Housewife (Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. 012 14 4060

16 BIRTHPLACE (City) Lexington Mass (State or country)

PARENTS

17 NAME OF FATHER Clarence W Fuller

18 BIRTHPLACE OF FATHER (City) Hyannis (State or country) Mass

19 MAIDEN NAME OF MOTHER Abbe White

20 BIRTHPLACE OF MOTHER (City) Lexington (State or country) Mass

21 Informant Frederick M. McCobb (Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)
Agent, Board of Health (Official Designation) Dec 3, 1955 (Date of Issue of Permit)

50M-10-53-910621

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

20.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Haynes, Marion E. (nee Wilson)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. East Main St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months....2...days. In place of residence....17...years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 5 (Day) 1955 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1947, to Dec. 4, 1955

I last saw her alive on Dec 4, 1955 death is said to have occurred on the date stated above, at 3:00a. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Arteriosclerotic Heart disease	8 yrs.
ANTECEDENT CAUSES Due To (b) Arteriosclerosis	?
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Emphysema, Chronic Bronchitis	yrs.

Major findings: Of operations No

Date of operation None Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) Timothy P. Stone, M. D.

(Address) Main St., South Boro Date 12/6 1955

6 Rural Cem., Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 7, 1955

7 NAME OF FUNERAL DIRECTOR Donald C Morris

ADDRESS Main St., Southboro

Received and filed Dec 14, 1955 19....

Walter E. Keefe
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Reuben Haynes
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years 3 Months 20 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Domestic
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Medford Mass.

PARENTS

17 NAME OF FATHER William H Wilson

18 BIRTHPLACE OF FATHER (City) Medford
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Mary Ann Hunt

20 BIRTHPLACE OF MOTHER (City).....
(State or country) Ireland

21 Informant Charles H. Haskell
(Address) Hopkinton

A TRUE COPY
ATTEST: W. A. Walsh
(Registrar of City or Town where death occurred)

DATE FILED December 9 1955

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Southboro (City or Town making this return)

Registered No. 21

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Framingham Road, Southboro, Mass St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jessie (Buchanan) Vaughan (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Framingham Road, Southboro, Mass St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 years ..... months ..... days. In place of residence 3 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: DECEMBER (Month) 21 (Day) 1955 (Year)

4 I HEREBY CERTIFY, That I attended deceased from DECEMBER 5 19 55 to DECEMBER 20 19 55

I last saw her alive on DECEMBER 21 19 55 death is said to have occurred on the date stated above, at 7 30 P m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) UREMIA	3 MONTHS
ANTECEDENT CAUSES Due To (b) GLOMERULO-NEPHRITIS chronic	10 YRS
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings:
Of operations.....
Date of operation..... Was autopsy performed?.....
What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify.....
(Signed) John Paul Chasan, M. D.
(Address) Medical Surgical Date 12/23 19 55

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Dec. 23, 1955 19

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main ST. Southboro, Mass

Received and filed December 23. 19 55
Custer & Kelly T.C.
(Registrar)
A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE / MARRIED / WIDOWED / or DIVORCED (write the word)
F	White	Married

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Courtland Vaughan
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 10 Months 15 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No. None

16 BIRTHPLACE (City) Greensburg, Ky.
(State or country)

PARENTS

17 NAME OF FATHER Henderson Parks Buchanan

18 BIRTHPLACE OF FATHER (City) ??
(State or country) Virginia

19 MAIDEN NAME OF MOTHER Susan P. Hutchinson

20 BIRTHPLACE OF MOTHER (City) could not be learned
(State or country)

21 Informant Mrs. Walter Norton
(Address) Framingham Rd, Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Bd of Health (Official Designation) Dec 22, 1955 (Date of Issue of Permit)

50M-10-53-910621

23

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK. — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-5-55-915025

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Fall River
(City or town making return)

Registered No. .....

1 PLACE OF DEATH: Bristol (County); Fall River (City or Town); No. Rose Hawthorne Lathrop Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Michael J. McCarthy (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Boston Rd. St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 2 months 16 days. In place of residence 64 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 23, (Day) 1955 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1955, to Dec. 23, 1955

I last saw him alive on Dec. 22 1955, death is said to have occurred on the date stated above, at 3:00 a.m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma of Face — INTERVAL BETWEEN ONSET AND DEATH: 4yrs.

ANTECEDENT CAUSES Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations? — Biopsy - Carcinoma

Date of operation ..... Was autopsy performed? No

What test confirmed diagnosis? Microscopic

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Joseph G. Norman

(Address) 1675 So. Main St. Date 12-23 1955 M. D.

6 Rural Cem. Southboro (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL December 26, 1955

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed Jan. 27 1956

Mary E. Kelly Asst Clerk

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced HUSBAND of Angelina Dufault (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 64 Years - Months - Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Carpenter (Kind of work done during most of working life)

14 Industry or Business: Building

15 Social Security No. -----

16 BIRTHPLACE (City) (State or country) Southboro, Mass.

PARENTS

17 NAME OF FATHER: James McCarthy

18 BIRTHPLACE OF FATHER (City) (State or country): ----- Ireland

19 MAIDEN NAME OF MOTHER: Margaret Colleary

20 BIRTHPLACE OF MOTHER (City) (State or country): ----- Ireland

21 Informant (Address): Paul McCarthy Southboro, Mass.

A TRUE COPY

ATTEST: James J. Carey

(Registrar of City or Town where death occurred)

DATE FILED December 29, 1955

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town, in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham 22
(City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harris D. Eaton
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Flagg Rd. St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death .....years .....months 15 days. In place of residence 40 years .....months .....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 25, 1955
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 18, 1951 to Dec. 25, 1955

I last saw h.. im alive on Dec. 25, 1955 death is said to have occurred on the date stated above, at 6.50p m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Coronary sclerosis	sudden
ANTECEDENT CAUSES Due To (b)	Arteriosclerosis	4 yrs
Due To (c)	cerebral thrombosis	2 wks
OTHER SIGNIFICANT CONDITIONS	uremia(nephrosclerosis (pyelonephritis	6 mos

Major findings: Of operations.....

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) Timothy P. Stone M. D.
(Address) Southboro Date 12/26/55

6 North Burial Ground Prov. R.I.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Dec. 28, 1955 19....

7 NAME OF FUNERAL DIRECTOR William A. Leland
ADDRESS Northboro

Received and filed Dec 30, 1955 19....
(Registrar of City or Town where deceased resided)
Custer E Reed T.C.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	widowed

10a If married, widowed, or divorced
HUSBAND of Ella Calder
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years 11 Months 18 Days | If under 24 hours .....Hours .....Minutes

13 Usual Occupation: Dairy farmer
(Kind of work done during most of working life)

14 Industry or Business: retired

15 Social Security No. .....

16 BIRTHPLACE (City) Milltown
(State or country) New Brunswick

PARENTS

17 NAME OF FATHER George H. Eaton

18 BIRTHPLACE OF FATHER (City) .....
(State or country) CNBL

19 MAIDEN NAME OF MOTHER Elizabeth W. Boyden

20 BIRTHPLACE OF MOTHER (City) Amherst
(State or country) Mass.

21 Informant John Coolidge
(Address) Hudson, Mass.

A TRUE COPY
ATTEST: Wm J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED Dec. 28, 1955

M R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M.-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Wayland (City or Town making this return)

Registered No. 3

1 PLACE OF DEATH: Middlesex (County); Wayland (City or Town); No. Roycroft Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME HARRY LEONARD BAILEY (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Main St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 11 days. In place of residence 43 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 7, (Day) 1956 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 12, 1951, to January 7, 1956

I last saw him alive on January 7, 1956 death is said to have occurred on the date stated above, at 5:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Metastatic Carcinoma of Liver	33 mos.
Due To (b)	Carcinoma, sigmoid colon	33 mos.
Due To (c)	--	
OTHER SIGNIFICANT CONDITIONS	No	

Was autopsy performed? No
What test confirmed diagnosis? Pathologist's report

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) /s/ Timothy P. Stone M. D.
(Address) Main St., Southboro Mass. Date Jan. 8, 1956

6 Rural Cemetery, Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL January 10, 1956

7 NAME OF FUNERAL DIRECTOR Carl E. Willson
ADDRESS 318 Union Ave., Framingham

Received and filed March 31 1956
Quentin E. Kelly Town Clerk
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed or divorced HUSBAND of Dorothy Harwood (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 7 Months 4 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired (Kind of work done during most of working life)

14 Industry or Business: Bay State Abrasives

15 Social Security No.

16 BIRTHPLACE (City) Evesham (State or country) England

PARENTS

17 NAME OF FATHER Joseph Bailey

18 BIRTHPLACE OF FATHER (City) c.b.l. (State or country) England

19 MAIDEN NAME OF MOTHER Elizabeth Gardiner

20 BIRTHPLACE OF MOTHER (City) c.b.l. (State or country) England

21 Informant Mr. Gordon Bailey, son (Address) 7 Draper Rd., Natick, Mass.

A TRUE COPY
ATTEST: Leila Sears (Registrar of City or Town where death occurred)

DATE FILED January 9, 1956

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK. — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-(B)-11-51-905807

4

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town); No. Marlborough Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Marlborough (City or town making return)

2 FULL NAME Courtland Vaughan (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Framingham Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years 4 months.....days. In place of residence 3 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 7 (Day) 1956 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 55, to Jan 7 56

I last saw him alive on January 6, 1956, death is said to have occurred on the date stated above, at 6:20 A. m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Arteriosclerotic Heart Disease.	5 yrs.
ANTECEDENT CAUSES (b) Due To		
(c) Due To		
OTHER SIGNIFICANT CONDITIONS	Nephrosclerosis	10 yrs.

Major findings: Of operations.....

Date of operation.....Was autopsy performed? no

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) John Paul Ahearn M. D.

(Address) Marlborough Date Jan 8, 1956

6 Rural Cemetery Southboro, (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL Jan 9 1956

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed Feb. 2, 1956

Mary E. Kelly Asst Clerk

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Widowed

10a If married, widowed or divorced HUSBAND of Jessie Buchana (Give maiden name of wife in full)

(or) WIFE of.....(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 8 Months 6 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation:..... (Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No. 380-07-3834

16 BIRTHPLACE (City) Greensburg Ky. (State or country)

PARENTS

17 NAME OF FATHER John Richard Vaughan

18 BIRTHPLACE OF FATHER (City) Greensburg Ky. (State or country)

19 MAIDEN NAME OF MOTHER Fanny Beru Toomey

20 BIRTHPLACE OF MOTHER (City) Glasgow Ky. (State or country)

21 Informant Mrs. Walter Norton (Address) Framingham Rd. Southboro

A TRUE COPY ATTEST: Raymond D. Lavallee (Registrar of City or Town where death occurred)

Peter J. Gotowka Agent

DATE FILED January 8 1956

FORM R-301

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

50M-10-53-910621

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Southboro
(City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Southville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret A Donnell (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Southboro, Mass St. ..... (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 65 years ..... months ..... days. In place of residence 65 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 9 1956 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19 25, to present, 19.....

I last saw her alive on Jan 8, 19 56, death is said to have occurred on the date stated above, at 6.15 a. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Arterio Sclerosis	20yrs
ANTECEDENT CAUSES Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis? Clinically

5 Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) Walter F Morrow M. D.

(Address) Westboro Mass Date Jan 10 1956

6 St. Lukes Cemetery Westboro, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 12 19 56

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St Southboro, Mass

Received and filed Jan 18, 1956 19.....

Clinton E Kelly (Registrar).

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	White	Widowed

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Wm O'donnell
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 94 Years 11 Months 20 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) (State or country) Ireland

PARENTS

17 NAME OF FATHER Patrick Halley

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER could not be learned

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant (Address) Miss Josephine O'Donnell Southville Rd Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P Stone
(Signature of Agent of Board of Health or other)

agent board of health Jan 11, 1956
(Official Designation) (Date of Issue of Permit)

*minus dates of attendance

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M (E)-6-50-902253

2

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. .....

1 PLACE OF DEATH

Middlesex
(County)

Framingham
(City or Town)

No. Framingham Nursing Home 517 Nursing St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Julia Depuy (nee Eheny)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. ..... (Usual place of abode) Newton St. Southboro (If nonresident, give city or town and State)

Length of stay: In place of death .....years 9 months .....days. In place of residence 15 years .....months .....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan. 13, 1956
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Mar. 12, 19 53, to Jan. 13, 19 56

I last saw her alive on Jan. 12, 19 56 death is said to have occurred on the date stated above, at 12.14 p.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Thrombosis & gangrene gallbladder or mesentery	3 ds
ANTECEDENT CAUSES Due To (b)	Generalized arterio sclerosis	2yrs
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	cerebral thrombosis in past	

Major findings: Of operations .....

Date of operation ..... Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Timothy P. Stone, M. D.
(Address) Southboro Date 1/13/56

6 Rural Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan. 15, 1956

7 NAME OF FUNERAL DIRECTOR .....
ADDRESS .....

Received and filed Jan 18, 1956

Clerton Keedy
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
fe	W	wid

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of William Depuy (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 1 Months 10 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewfe (Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Orangeburgh S. C.

PARENTS

17 NAME OF FATHER Theodore Eheny

18 BIRTHPLACE OF FATHER (City) Athens
(State or country) Ga.

19 MAIDEN NAME OF MOTHER Elizabeth A, Chaplin

20 BIRTHPLACE OF MOTHER (City) Beauford
(State or country) S. C.

21 Informant Mrs. Frank Leslie
(Address) Southboro

A TRUE COPY
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED Jan. 16, 1956

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

Note:- Chapter 137, Acts of 1954, requires Physicians to print or type the cause or causes of death on death certificates.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Note Copy - 3

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Main Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME WILBUR, Addie Victoria (Sadler)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Main St. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: February (Month) 16 (Day) 1956 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 24, 1951, to February 16, 1956
I last saw her alive on February 16, 1956, death is said to have occurred on the date stated above, at 6:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cerebral Thrombosis — 6 hrs

Due To (b) Arteriosclerosis, generallized — over 5 yrs

Due To (c) age

OTHER SIGNIFICANT CONDITIONS: Arteriosclerotic Heart Disease — 5 yrs

Was autopsy performed? no
What test confirmed diagnosis? clinical.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify.....

(Signed) Timothy P. Stone, M. D.
(Address) Main St, Southboro Date Feb. 16 1956

6 Mt. Auburn Cemetery Cambridge, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Feb. 20, 1956

7 NAME OF FUNERAL DIRECTOR Eastman Funeral Service Inc.
ADDRESS 896 Beacon St., Boston, Mass.

Received and filed Feb. 20 1956
Mary S Kelly (Asst Clerk)
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Jacob Wesley Wilbur
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 90 Years - Months 28 Days. If under 24 hours .....Hours.....Minutes

13 Usual Occupation: None
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No. None

16 BIRTHPLACE (City) Georgetown,
(State or country) Maine.

PARENTS

17 NAME OF FATHER Benjamin Sadler

18 BIRTHPLACE OF FATHER (City).....
(State or country) Maine.

19 MAIDEN NAME OF MOTHER Susan Potter

20 BIRTHPLACE OF MOTHER (City).....
(State or country) Maine.

21 Informant Ruth W. Harrington, Daughter
(Address) Main St., Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) Feb 18, 1956 (Date of Issue of Permit)

100M-11-55-916145

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M.-11-35-9716145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough (City or Town making this return)

Registered No. 54

1 PLACE OF DEATH

MIDDLESEX (County)

MARLBOROUGH (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Arthur I. Melendy
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Ward Road (Usual place of abode) Southboro, Mass (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 3 days. In place of residence 28 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 26, 1956 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 10, 19 55 Feb 26, 19 56

I last saw h alive on Feb 25, 1956 death is said to have occurred on the date stated above, at 1.45 Am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2-23 Yrs

Due To (b) Arteriosclerosis

Due To (c) Diabetes Mellitus

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) C.W. Smith, M. D.

(Address) Marlborough, Date Feb 26, 1956

6 Main Street, Hudson, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb 28, 1956

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass

Received and filed Feb. 29. 1956

March 19, 1956 Curtis S Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M

9 COLOR W

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced HUSBAND of Hattie M. McConnell
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 4 Months 24 Days

If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Superintendent
(Kind of work done during most of working life)

14 Industry or Business: Walnut Hill Nursing Home

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Thedford, Vt.

PARENTS

17 NAME OF FATHER Cannot be learned

18 BIRTHPLACE OF FATHER (City) (State or country) Cannot be learned

19 MAIDEN NAME OF MOTHER Cannot be learned

20 BIRTHPLACE OF MOTHER (City) (State or country) Cannot be learned

21 Informant John Finn
(Address) Southboro, Mass

A TRUE COPY
ATTEST: Raymond D Lovell
(Registrar of City or Town where death occurred)

DATE FILED Feb 29, 1956

FORM R-301

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

5

Registered No. 263

Southboro (City or Town making this return)

PLACE OF DEATH

1 Worcester (County)

Southboro (City or Town)

No. Central St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mrs. Nancy (Ruggiero) Stifano
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Central St Fayville St. Fayville, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 17 years ... months ... days. In place of residence 17 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 18 (Day), 1956 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1954, to Mar 18, 1956

I last saw her alive on March 17, 1956, death is said to have occurred on the date stated above, at 1:50 a. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Massive Gastrointestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

Due To (b) ? Cancer, stomach — indefinite

Due To (c)

OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Disease 2 yrs+

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Timothy P. Stone, M. D.

(Address) Main St, Southboro, Mass (State) Mar. 19, 1956

6 Rural Cemetery Southboro, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 21, 1956

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St Southboro, Mass

Received and filed March 21, 1956

Courtis E Kelly (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: White

10 SINGLE / MARRIED / WIDOWED / or DIVORCED (write the word): Widow

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Louis Stifano
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years 10 Months 5 Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) Salerno (State or country) Italy

PARENTS

17 NAME OF FATHER Bartholomew Ruggiero

18 BIRTHPLACE OF FATHER (City) could not be Learned (State or country) Italy

19 MAIDEN NAME OF MOTHER Could not be learned

20 BIRTHPLACE OF MOTHER (City) Italy (State or country) Italy

21 Informant Mrs. Vera Amorelli
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) March 19, 1956 (Date of Issue of Permit)

100M-11-55-916145

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M.11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

GRAFTON (City or Town making this return) 8

Registered No. .....

1 PLACE OF DEATH: WORCESTER (County); GRAFTON (City or Town)

No. Grafton Convalescent Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Bertice B. Brigham (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Marlboro Road, St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 1 months ..... days. In place of residence 2 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 26th (Day) 1956 (Year)

4 I HEREBY CERTIFY, That I attended deceased from January, 1953 to March 26, 1956

I last saw him alive on March 26 1956, death is said to have occurred on the date stated above, at 12:00 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemmorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

Due To (b) Arteriosclerotic Heart Disease — 2 yrs.

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS .....

Was autopsy performed? no

What test confirmed diagnosis? Clinical Findings

5 Was disease or injury in any way related to occupation of deceased? If so, specify no

(Signed) Wilfred Cochrone, M. D.

(Address) Westboro, Mass. Date 3/27 1956

6 Place of Burial or Cremation Pine Grove Cemetery, Westboro, Mass. (City or Town)

DATE OF BURIAL March 28, 1956

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS 62 West Main St., Westboro Mass.

Received and filed April 10, 1956

Walter E. Kelly (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male | 9 COLOR: White | 10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced HUSBAND of Mary E. Sprague (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years 9 Months 9 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Stationery Engineer (Kind of work done during most of working life)

14 Industry or Business: Lumber Co. Retired

15 Social Security No. 021-16-8605

16 BIRTHPLACE (City) (State or country) Ayer, Mass.

PARENTS

17 NAME OF FATHER Levi Samuel Brigham

18 BIRTHPLACE OF FATHER (City) Ayer, (State or country) Mass.

19 MAIDEN NAME OF MOTHER Levi Samuel Brigham

20 BIRTHPLACE OF MOTHER (City) Ayer (State or country) Mass.

21 Informant (Address) Mrs. Louie Hoffman Marlboro Rd., Southboro, Mass

A TRUE COPY ATTEST: Raymond D. Jordan (Registrar of City or Town where death occurred)

DATE FILED March 27, 1956

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-5-52-907046

10

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 84

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town)

No. In Woods off East Main St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elizabeth Jane Clusen (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Boston Rd. (Usual place of abode) x St. Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence ..... years 2 months 12 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 13 (Day) 1956 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Under investigation
Waiting Autopsy Findings

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19 .....

Where did Injury occur? Westborough, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Woods - East Main St. (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? No Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Walter F. Mahoney M. D.

(Address) Westboro, Mass. Date 4/15/ 1956

7 Evergreen Cem., Manitowoc, Wisconsin
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL April 19, 1956

8 NAME OF FUNERAL DIRECTOR Robert K. Wadsworth

ADDRESS Framingham, Mass.

Received and filed May 11, 1956 19 .....

Evelyn F. Keeley Town Clerk
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Single

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 35 Years 9 Months 4 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Office Secretary (Kind of work done during most of working life)

15 Industry or Business: 034 - 12 - 4925

16 Social Security No. .....

17 BIRTHPLACE (City) Manitowoc, (State or country) Wisconsin

PARENTS

18 NAME OF FATHER Henry Clusen

19 BIRTHPLACE OF FATHER (City) (Manitowoc County) (State or country) Wisconsin

20 MAIDEN NAME OF MOTHER Paula Voelker

21 BIRTHPLACE OF MOTHER (City) Manitowoc (State or country) Wisconsin

22 Informant (Address) Mrs. Dorothy V. Clopeck (Aunt) 7 Raymond St. Framingham, Mass.

A TRUE COPY.
ATTEST: Annie R. Dunne
(Registrar of City or Town where death occurred)

DATE FILED April 15, 1956

COPY OF CERTIFICATE OF DEATH

14

CERTIFICATE OF DEATH
STATE OF NEW HAMPSHIRE

TOWN OR CITY
CLERK'S NO

1. NAME OF DECEASED (Type or Print)	a. (First) Claudia	b. (Middle) W.	c. (Last) Plante	2. DATE OF DEATH (Month) (Day) (Year)	April 23, 1956						
3. PLACE OF DEATH a. COUNTY	Strafford			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE	Mass.	b. COUNTY	Worcester				
b. CITY OR TOWN	Dover	c. LENGTH OF STAY (in this place)		c. CITY OR TOWN (Give actual town of residence, NOT mailing address).	Southboro						
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	Wentworth-Dover Hospital			d. STREET ADDRESS (If rural, give location)	Break Hill Road						
5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.			
Female	White	Widowed	Sept. 29, 1880	75							
10a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?								
Housework	Own Home	Canada	USA								
13. FATHER'S NAME	Lazare Brochu			14. MOTHER'S MAIDEN NAME	Marie Goulet						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.		17. INFORMANT	Rev. Leo A. Plante						
No											

18. MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

(a) Massive Hemorrhage left pleural cavity

DUE TO

(b) Multiple rib fractures

DUE TO

(c)

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

INTERVAL BETWEEN ONSET AND DEATH: 1 hour or less

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing it.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY OR TOWN)	(COUNTY)	(STATE)
ACCIDENT	Highway	Dover	Strafford	N.H.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
4/23/56 12:00 p.m.		Auto Accident

22. *I hereby certify that I attended the deceased from* 4/23, 19 56, *to* 4/23, 19 56, *that I last saw the deceased alive on* no., 19 ....., *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Samuel J. King, M. D.	Rochester, N. H.	4/23/1956

24a. BURIAL, CREMATION, ENTOMBMENT, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	4/26/1956	St. Anne Cemetery	Berlin, N. H.

IF ENTOMBED 24e. PLACE OF BURIAL (Name of Cemetery)	LOCATION (City, Town, County) (State)	DATE

25. FUNERAL DIRECTOR ADDRESS	COUNTERSIGNED - AGENT (City Bd. of Health)	DATE
Henry J. Grondin, Rochester, NH	Dr. Max Winer	4/23/1956

DATE REC'D BY TOWN OR CITY CLERK	CLERK'S OWN SIGNATURE	CLERK OF
April 24, 1956	Alfred J. Guilmette	Dover, N. H.

A true copy, Attest: Alfred J. Guilmette *Clerk of* Dover, N.H. *Dated* 6/1 19 56

V. S. 17

1-53-50M

City Clerk

Recorded & Filed June 20, 1956 Austin E. Kelly Town Clerk.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham 11
(City or Town making this return)

Registered No. .....

1 PLACE OF DEATH
Middlesex (County)
Framingham (City or Town)
No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George T. Firmin
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Main St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death .....years .....months 4 days. In place of residence 50 years .....months .....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 28, 1956
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 24, 1956 to April 28, 1956

I last saw ~~him~~ alive on April 28, 1956, death is said to have occurred on the date stated above, at 10.30A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Uremia	3 mos
Due To (b) Hypertensive cardio casvular disease	2-3yrs
Due To (c) hypertension	20 yrs
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? no
What test confirmed diagnosis? lab. tests

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signed) Donald S. Love M. D.
(Address) Framingham Date 4/28/56

6 Rural Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 30, 1956

7 NAME OF FUNERAL DIRECTOR Wm. M. Tighe
ADDRESS Marlboro

Received and filed May 2, 1956

Austin E. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
male	white	married

10a If married, widowed, or divorced HUSBAND of Catherine Pilkinton
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years 11 Months .....Days | If under 24 hours .....Hours .....Minutes

13 Usual Occupation: retired tailor
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. 030-03-8588

16 BIRTHPLACE (City) (State or country) England

PARENTS

17 NAME OF FATHER cnbl

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER cnbl

20 BIRTHPLACE OF MOTHER (City) (State or country) England

21 Informant Mary J. Firmin
(Address) Southboro

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED April 30, 1956

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

17

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough (City or Town making this return)

Registered No. 101 ~~267~~

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town)

No. Marlboro, Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Hannah G. Bagley (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. White Bagley Rd. St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: May (Month) 3 (Day) 1956 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 9, 1954 to May 3, 1956, I last saw h... alive on May 3, 1956 death is said to have occurred on the date stated above, at 3:05 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Due To (b) Hypertension — yrs.

Due To (c) Arteriosclerotic Heart Disease

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? yes
What test confirmed diagnosis? Routine

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Allen H. Knapp, M. D.

(Address) Westborough, Date May 3, 1956

6 Rural Cemetery Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 5, 1956

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed May 8 1956

Raymond D. Lavallee
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: W

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): S

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

AGE 69 Years 6 Months 6 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At Home (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Southboro, Mass.

PARENTS

17 NAME OF FATHER Thomas H. Bagley

18 BIRTHPLACE OF FATHER (City) Charlton, Mass. (State or country)

19 MAIDEN NAME OF MOTHER Mary Carrigan

20 BIRTHPLACE OF MOTHER (City) Northboro (State or country)

21 Informant Genevieve Bagley (Address) Southboro, Mass.

A TRUE COPY
ATTEST: June 29, 1956
(Registrar of City or Town where death occurred)

DATE FILED Austin E. Kelly 19
Town clerk

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

18

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough (City or Town making this return)

Registered No. 103

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town); No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Dorothy Mabie (Hadley) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Rd. St. Fayville (If nonresident, give city or town and State) (Usual place of abode)

Length of stay: In place of death ..... years ..... months 12 days. In place of residence 44 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 5 (Month) 4 (Day) 56 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 4-22, 1956, to 5-4-, 1956

I last saw her alive on 5-4-, 1956, death is said to have occurred on the date stated above, at 8:20 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

Due To (b) mal nutrition

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Kenneth R. Greenleaf, M. D.

(Address) Marlboro Date 5/5/ 1956

6 Rural Southboro Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 7 1956

7 NAME OF FUNERAL DIRECTOR William M. Tighe

ADDRESS 3 Windsor St. Marlboro

Received and filed 5/8 19

Raymond D. Lamb

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: W

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): W

10a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of William Mabil (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 62 Years 5 Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: at home (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER Osgood Hadley

18 BIRTHPLACE OF FATHER (City) (State or country) Peterboro n H.

19 MAIDEN NAME OF MOTHER Josephine Scanlon

20 BIRTHPLACE OF MOTHER (City) (State or country) Lawrence Mass.

21 Informant Newell Mabie son

(Address) Webster Rd. Ashland

A TRUE COPY

ATTEST: June 29, 1956 [illegible] M. D.

(Registrar of City or Town where death occurred)

DATE FILED Curtis E. Kelly 19

Town Clerk

50M-11-55-916145

FORM R-303 A

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-3-54-911887

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 9

PLACE OF DEATH

1 (County) WORCESTER

(City or Town) SOUTHBOROUGH

No. Central Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MARY BELLIVEAU
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Central Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY (Month) 12 (Day) 1956 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

CEREBRAL HEMORRHAGE

ARTERIO SCLEROSIS

5 Accident, suicide, or homicide (specify) [illegible]

Date and hour of injury ..... 19..

Where did Injury occur? [illegible]
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?
(Specify type of place)

Manner of Injury
(How did injury occur?)

Nature of Injury

While at work? NO Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) Walter J. Mahoney, M. D.

(Address) Westborough Mass Date May 12 1956

7 Notre Dame Cemetery Worcester
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL May 15 19 56

8 NAME OF FUNERAL DIRECTOR James E. Fay

ADDRESS 9 Hammond Street, Worcester

Received and filed May 16 1956 19..

Austin E. Kelly (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Female

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Austin Belliveau
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 80 Years 2 Months 25 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: House Wife
(Kind of work done during most of working life)

15 Industry or Business: At home

16 Social Security No. none

17 BIRTHPLACE (City) Midbury
(State or country) Mass.

PARENTS

18 NAME OF FATHER Louis Morrel

19 BIRTHPLACE OF FATHER (City) .....
(State or country) Canada

20 MAIDEN NAME OF MOTHER Mary Rainville

21 BIRTHPLACE OF MOTHER (City) .....
(State or country) Canada

22 Informant Paul Belliveau (Son)
(Address) Central Street

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Shone
(Signature of Agent of Board of Health or other)

Agent, Bd. of Health 5/14/56
(Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M.-11-55-916145

12

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mrs. Josephine (Aspesi) Rabeni
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Central St. St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 1 months 7 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 18, (Day) 1956 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 12 1956, to May 18, 1956

I last saw her alive on May 18, 1956, death is said to have occurred on the date stated above, at 9:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Broncho Pneumonia	2 da
Due To (b)	Carcinomatosis	3 mo
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Diverticulitis Colon	3 mo

Was autopsy performed? No
What test confirmed diagnosis? Biopsy Lymph-nodes

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) Lee G. Kendall, M. D.
(Address) 198 Union Ave. Date 5/20 1956

6 Rural Cem., Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 21 1956

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St., Southboro, Mass.

Received and filed May 28, 1956
Curtis E. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Joseph Rabeni
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 73 Years 1 Months 27 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Home

15 Social Security No. -----

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER: Charles Aspesi

18 BIRTHPLACE OF FATHER (City) (State or country): Italy

19 MAIDEN NAME OF MOTHER: Theresa Colombo

20 BIRTHPLACE OF MOTHER (City) (State or country): Italy

21 Informant (Address): John Rabeni Central St., Fayville

A TRUE COPY
ATTEST: Wm. A. Walsh
(Registrar of City or Town where death occurred)

DATE FILED May 23 1956

FORM R-303 A

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-3-54-911887

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 13

1 PLACE OF DEATH
(County) Worcester
(City or Town) Southboro
No. Turnpike Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Massie L. Trioli
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Rd St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 29 1956
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

FRACTURED SKULL

5 Accident, suicide, or homicide (specify) MAY 29 56
Date and hour of injury ACCIDENT 19
Where did Injury occur? SOUTHBOROUGH MASS
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? HIGHWAY ROUTE #9
(Specify type of place)
Manner of Injury HIT BY AUTOMOBILE
(How did injury occur?)
Nature of Injury FRACT SKULL
While at work? NO Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased? NO
If so, specify
(Signed) Walter F Mahoney, M. D.
(Address) Westborough Mass Date MAY 30 1956

7 Rural Southboro
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL June 1st 1956

8 NAME OF FUNERAL DIRECTOR William M Tickle
ADDRESS 2 Kimball St Marlboro

Received and filed May 31 1956 19
Austin E Kelly.
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male
10 COLOR OR RACE White
11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Single

11a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 59 Years 7 Months 8 Days
If under 24 hours Hours Minutes

14 Usual Occupation: Farmer Farm
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No 019-26-6576

17 BIRTHPLACE (City) (State or country) Southboro Mass

PARENTS

18 NAME OF FATHER John Trioli
19 BIRTHPLACE OF FATHER (City) (State or country) Italy
20 MAIDEN NAME OF MOTHER Clementina Cardani
21 BIRTHPLACE OF MOTHER (City) (State or country) Italy

22 Informant (Address) Mrs Thomas O'Brien Sister Turnpike Rd Fayville mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Horne M.D.
(Signature of Agent of Board of Health or other)
Agent, Board of Health May 30, 1956
(Official Designation) (Date of Issue of Permit)

FORM R-301

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Southboro (City or Town making this return)

Registered No. 263

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Turnpike Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Pasquale Mauro (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. TurnPike Road Southboro, Mass St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 70 years ..... months ..... days. In place of residence 70 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 19 (Day) 1956 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 28, 1952, to June 19, 1956

I last saw him alive on June 13, 1956, death is said to have occurred on the date stated above, at 12:30 a.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral Thrombosis	22 days
ANTECEDENT CAUSES Due To (b) Arteriosclerosis, general	years
Due To (c) Several Cerebral Thromboses since August 20, 1952	
OTHER SIGNIFICANT CONDITIONS no	

Major findings: Of operations no

Date of operation none Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify —

(Signed) Timothy P. Stone, M. D.

(Address) Main St., Southboro Date June 19 1956

6 Rural Cemetery Southboro, Mass (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL June 21, 56

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass

Received and filed June 22, 1956

Austin F. Kelly (Registrar)

A TRUE COPY ATTEST: Town clerk

50M-10-53-910621

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
M	White	Widowed

10a If married, widowed, or divorced HUSBAND of Rachel (Gorga) Mauro (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 8 Months 22 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Farmer (Kind of work done during most of working life)

14 Industry or Business: Market Gardening

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Roccadiaspa Italy

PARENTS

17 NAME OF FATHER Carmine Mauro

18 BIRTHPLACE OF FATHER (City) Could not be learned (State or country) Italy

19 MAIDEN NAME OF MOTHER Marianne Waidna

20 BIRTHPLACE OF MOTHER (City) Could not be Learned (State or country) Italy

21 Informant Marion Mauro (Address) Turnpike Road Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) June 20, 1956 (Date of Issue of Permit)

FORM R-303 A

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-3-54-911887

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 19

1 PLACE OF DEATH
Worcester (County)
Southville (City or Town)
No. Southville Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary E Burke (DONAVAN)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Rd St. Southville Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 35 years ..... months ..... days. In place of residence 35 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 24 (Day) 1956 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury ..... 19 .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury ..... (How did injury occur?)
Nature of Injury .....
While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Walter J Mahoney, M. D.
(Address) Westborough Mass Date 7-24 1956

7 St Joseph's Lynn Mass
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL July 27 1956

8 NAME OF FUNERAL DIRECTOR John W Sullivan
ADDRESS 375 Lincoln St Marlboro Mass

Received and filed July 27 1956 19 .....
Martin Kelly (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female | 10 COLOR OR RACE White | 11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Frank Burke (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 73 Years 10 Months 24 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Saleswomen Ladies Apparel (Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. 020-20-5953

17 BIRTHPLACE (City) (State or country) Lynn Mass

PARENTS

18 NAME OF FATHER John Donovan

19 BIRTHPLACE OF FATHER (City) (State or country) Ireland

20 MAIDEN NAME OF MOTHER Mary Heaphy

21 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

22 Informant Miss Nora Donovan niece
(Address) Middleton Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent Bd of Health July 26, 1956.
(Official Designation) (Date of Issue of Permit)

16

FORM R-303 A

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-3-54-911887

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

PLACE OF DEATH

1 Worcester (County)
Southborough (City or Town)
No. Woodland Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Thomas J Fitzgerald
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Woodland Rd Southborough Mass St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 55 years ..... months ..... days. In place of residence 55 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 25 1956
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Internal injuries of chest and abdomen

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury June 24 - 1 P/M 1956

Where did Injury occur? Southborough Mass
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Highway
(Specify type of place)

Manner of Injury Ran into tree - driving his car
(How did injury occur?)

Nature of Injury Internal injuries - chest and abdomen

While at work? no Was autopsy performed? Refused

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Walter J Mahoney M. D.

(Address) Westborough Mass Date June 25 1956

7 Rural Cemetery Southboro
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL June 28 1956

8 NAME OF FUNERAL DIRECTOR T. H. Callanan & Son

ADDRESS Hopkinton, Mass

Received and filed June 27 1956

Custus E Kelly / Town Clerk.
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male

10 COLOR OR RACE White

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

11a If married, widowed, or divorced HUSBAND of Florence Finn
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 55 Years 11 Months 23 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Grocery clerk
(Kind of work done during most of working life)

15 Industry or Business: Grocery store

16 Social Security No. 013-01-6599

17 BIRTHPLACE (City) (Cordaville) Southboro
(State or country) Massachusetts

PARENTS

18 NAME OF FATHER Thomas Fitzgerald

19 BIRTHPLACE OF FATHER (City) .....
(State or country) Ireland

20 MAIDEN NAME OF MOTHER Margaret Healy

21 BIRTHPLACE OF MOTHER (City) Acton
(State or country) Massachusetts

22 Informant Mrs Florence Fitzgerald
(Address) Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of Health June 26, 1956
(Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-91645

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

22

Registered No. 181

1 PLACE OF DEATH

MIDDLESEX (County)

MARLBOROUGH (City or Town)

MARLBOROUGH (City or Town making this return)

No. Pleasant View Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Louise Lamprey
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. (Usual place of abode) Upland Road Southboro, Mass (If nonresident, give city or town and State)

Length of stay: In place of death 1 years ... months ... days. In place of residence 90 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept 10, 1956 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 1, 56, to Sept 10, 56, 19...

I last saw her alive on Sept 10, 19 56 death is said to have occurred on the date stated above, at 5 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Arteriosclerotic heart disease	1 yr
Due To (b)	arteriosclerosis	15 yr
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? no

What test confirmed diagnosis? phy. exam

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) William D. Roche, M. D.

(Address) Marlborough, Date 9-11-56

6 Rural Southboro, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 12, 1956

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass

Received and filed Sept 14 1956

Nov 8, 1956 Austin E Kelley
(Registrar of City or Town where deceased resided)

Town Clerk

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
F	W	Widowed

10a If married, widowed, or divorced
HUSBAND of ...
(Give maiden name of wife in full)

(or) WIFE of Noval Lamprey
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 91 Years 2 Months 11 Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: home

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Southboro, Mass

PARENTS

17 NAME OF FATHER Charles B. Lamprey

18 BIRTHPLACE OF FATHER (City) (State or country) Southboro, Mass

19 MAIDEN NAME OF MOTHER Louise McMaster

20 BIRTHPLACE OF MOTHER (City) (State or country) Southboro, Mass

21 Informant Miss Ruth Sawin
(Address) Southboro

A TRUE COPY
ATTEST: Raymond D. Lamb
(Registrar of City or Town where death occurred)

DATE FILED ... 19...

FORM R-301A

20

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southbora (City or Town) — No. Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Catherine F. Irwin (Pilkington) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Main St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 50 years ..... months ..... days. In place of residence ..... years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires Physicians to print or type the cause or causes of death on death certificates.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 18th 1956 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1956 to Oct. 18, 1956

I last saw her alive on Oct 17, 1956 death is said to have occurred on the date stated above, at 5:30 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Uremia	2 days
Due To (b) Chronic Nephritis	1 yr.
Due To (c) Inflamatory Uremia	6 mo
OTHER SIGNIFICANT CONDITIONS Arterio - sclerosis Senility	

Was autopsy performed? no
What test confirmed diagnosis? Laboratory Tests

5 Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) J. D. Kable, M. D.
(Address) 42 Main St Marlboro Date Oct 18 1956

6 Rural Southbora Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 20 1956

7 NAME OF FUNERAL DIRECTOR William M Tighe
ADDRESS Windsor St Marlboro

Received and filed October 19 1956
Quintin E Kelly (Registrar)
Town Clerk

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female | 9 COLOR: White | 10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of George F. Irwin (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 Years ..... Months 8 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. —

16 BIRTHPLACE (City) (State or country) Ireland

PARENTS

17 NAME OF FATHER Ambrose Pilkington

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Bridget Corrigan

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Mary J. F. Irwin (Address) Main St Southbora

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)
Agent Bd of Health. (Official Designation) Oct 18, 1956 (Date of Issue of Permit)

100M-11-55-916145

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

21

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Gertrude E. Hunt (nee Cady) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Southville Rd. St. Southboro (If nonresident, give city or town and State) (Usual place of abode)

Length of stay: In place of death ..... years ..... months 7 days. In place of residence 34 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH (Month) Nov. (Day) 2, (Year) 1956

4 I HEREBY CERTIFY, That I attended deceased from Oct. 27 1956; to Nov. 2, 1956

I last saw her alive on Nov. 2, 1956 death is said to have occurred on the date stated above, at 1 - pm.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Myocardial infarction	10 ds
ANTECEDENT CAUSES (b) Due To	
(c) Due To	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis? ECG

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Mark S. Wellington M. D.

(Address) Framingham Date 11/3 1956

6 Rural Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 5, 1956 19

7 NAME OF FUNERAL DIRECTOR John W. Sullivan

ADDRESS Marlboro

Received and filed Nov 7, 1956 19

Grace E. Kelly Town Clerk
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
fem	white	married

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of John A. Hunt
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 73 Years 2 Months 9 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At home
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

17 NAME OF FATHER John P. Cady

18 BIRTHPLACE OF FATHER (City) Waltham (State or country) Mass.

19 MAIDEN NAME OF MOTHER --- Soufnie

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) CNBL

21 Informant John Hunt
(Address) Southboro

A TRUE COPY
ATTEST: Grace E. Walsh
(Registrar of City or Town where death occurred)

DATE FILED Nov. 6, 1956 19

23

FORM R-303 A

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-3-54-911887

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 263

1 PLACE OF DEATH: Worcester (County); Southborough (City or Town); No. Southville Road St. Southboro, Mass (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME GEMMA SORA (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Rd. Southboro, Mass St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 10 years ..... months ..... days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOVEMBER 14 1956 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

SUDDEN DEATH PRESUMABLY CORONARY - THROMBOSIS

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? NO Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased? NO

If so, specify .....

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Mass Date Nov 14 1956

7 Rural Cemetery Southboro Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Nov. 17, 1956 19....

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St Southboro, Mass

Received and filed Nov. 19, 1956 19....

Quentin E. Kelley, R.C. (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: F

10 COLOR OR RACE: White

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Joseph Sora (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 69 Years 2 Months 15 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Housewife (Kind of work done during most of working life)

15 Industry or Business: At Home

16 Social Security No. 015-12-1043

17 BIRTHPLACE (City) (State or country) Isola Dellriano Italy

PARENTS

18 NAME OF FATHER Edward Boratti

19 BIRTHPLACE OF FATHER (City) Italy (State or country)

20 MAIDEN NAME OF MOTHER Could not be Learned

21 BIRTHPLACE OF MOTHER (City) Italy (State or country)

22 Informant Mrs. Benita Hubley
(Address) Southville Rd. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone, M.D. (Signature of Agent of Board of Health or other)

Agent Bd of Health (Official Designation) Nov 16, 1956 (Date of Issue of Permit)

FORM R-303 A

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-3-54-911887

24

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH
(County) Worcester
(City or Town) Southborough
No. Fay School St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Oscar Saunders
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 42 Farm Road St. Marlborough
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 9 months ..... days. In place of residence 6 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 30 1956
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
SUDDEN DEATH PRESUMABLY CORONARY THROMBOSIS

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury ..... 19 .....
Where did Injury occur? .....
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)
Manner of Injury .....
(How did injury occur?)
Nature of Injury .....
While at work? No Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased? NO
If so, specify .....
(Signed) Walter J Mahoney, M. D.
(Address) Westborough Mass Date 11-30 1956

7 Pine Hill Cemetery, W. Bridgewater
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL Dec. 2 1956

8 NAME OF FUNERAL DIRECTOR C E Shepherd
ADDRESS Weymouth, Mass

Received and filed December 3, 1956
Justin E. Kelly (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male
10 COLOR OR RACE White
11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

11a If married, widowed, or divorced HUSBAND of Mary Ellis
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 74 Years 9 Months 16 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Caretaker
(Kind of work done during most of working life)

15 Industry or Business: St Mark's Academy

16 Social Security No. 024-03-4260

17 BIRTHPLACE (City) Lynn
(State or country) Massachusetts

PARENTS

18 NAME OF FATHER Edgar Saunders

19 BIRTHPLACE OF FATHER (City) Cannot be learned
(State or country) Nova Scotia

20 MAIDEN NAME OF MOTHER Martha Durkee

21 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country) Nova Scotia

22 Informant Mary Saunders
(Address) 42 Farm Rd. Marlborough

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Bd of Health Nov 30, 1956
(Official Designation) (Date of Issue of Permit)

ORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, with unfading black ink — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. .....

1 PLACE OF DEATH

Middlesex
(County)

Framingham
(City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Fred C. Twombly
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Parkerville Rd., St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death .....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan. 6, 1957
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 3, 1950, to Jan. 6, 1957

I last saw him alive on Jan. 6, 1957 death is said to have occurred on the date stated above, at 4.35p m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral hemorrhage	5 hrs
ANTECEDENT CAUSES Due To (b) hypertension arteriosclerosis	7 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings:
Of operations.....
Date of operation..... Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify.....
(Signed) Timothy P. Stone M. D.
(Address) Southboro Date 1/7/57

6 Pine Hill Dover, N. H.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL 1/8/57

7 NAME OF FUNERAL DIRECTOR S. O. Wood
ADDRESS Hopkinton

Received and filed Jan 18 1957
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
male	white	married

10a If married, widowed, or divorced
HUSBAND of Alice Long
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 6 Months 15 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Machine shop
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 017-24-2522

16 BIRTHPLACE (City) Madbury
(State or country) N. H.

PARENTS

17 NAME OF FATHER William H. Twombly

18 BIRTHPLACE OF FATHER (City) Madbury
(State or country) N. H.

19 MAIDEN NAME OF MOTHER Mary Hall

20 BIRTHPLACE OF MOTHER (City) Barrington
(State or country) N. H.

21 Informant Constance T. Sherman
(Address) Southboro

A TRUE COPY
ATTEST: W. A. Walsh
(Registrar of City or Town where death occurred)

DATE FILED Jan. 17, 1957

M R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 6

1 PLACE OF DEATH: Middlesex (County); Marlboro (City or Town); No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Girl Cibelli (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. Newton St (Usual place of abode) St. Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 7 (Day) 1957 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1957 to Jan. 7, 1957

I last saw her alive on January 7, 1957 death is said to have occurred on the date stated above, at 8:05 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Scleroderma — INTERVAL BETWEEN ONSET AND DEATH: 16 Hrs

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) R. A. Johnson, M. D.

(Address) Marlboro, Mass. Date 1/8 1957

6 Rural Cemetery Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 9 1957

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed January 10 1957

March 22, 1957 Custo-E Kelly

(Registrar of City or Town where deceased resided)

50M-11-55-916145

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE Years Months 2 Days — If under 24 hours Hours Minutes

13 Usual Occupation: None (Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City) Marlboro (State or country) Mass.

PARENTS

17 NAME OF FATHER: Raymond M. Cibelli

18 BIRTHPLACE OF FATHER (City) Marlboro (State or country) Mass.

19 MAIDEN NAME OF MOTHER: Vernelle Thomas

20 BIRTHPLACE OF MOTHER (City) Marlboro (State or country) Mass.

21 Informant. Raymond M. Cibelli (Address) Newton St. Southboro, Mass.

A TRUE COPY ATTEST: Raymond D. Lavallee (Registrar of City or Town where death occurred)

DATE FILED January 8 1957

ORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(c)-11-49-900.475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or town making return)

Registered No. 7

1 PLACE OF DEATH: Middlesex (County); Marlboro (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Donna M. Watkins (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) none

(a) Residence. No. Southville Road St. Southville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 9 (Day) 1957 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Acute Primary Peritonitis
Supperative possibly due to
Septicemia

5 Accident, suicide, or homicide (specify) No

Date and hour of injury ..... 19 .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Arthur G. Richer, M. D.

(Address) Hudson, Mass. Date 1/4 19 57

7 Dell Park Cemetery Natick, Mass
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL January 12 19 57

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed ~~January 11~~ March 22, 1957 19 57

Cynthia E. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	White	Single

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 11 Years 4 Months 27 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: School girl (Kind of work done during most of working life)

15 Industry or Business: Public School

16 Social Security No. .....

17 BIRTHPLACE (City) Natick (State or country) Mass.

PARENTS

18 NAME OF FATHER Warren J. Watkins

19 BIRTHPLACE OF FATHER (City) Ashville (State or country) Penn.

20 MAIDEN NAME OF MOTHER Dorothy R. McKinstry

21 BIRTHPLACE OF MOTHER (City) Natick (State or country) Mass.

22 Informant Warren J. Watkins (Address) Southville, Mass.

A TRUE COPY. Raymond D. Lavallee
ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Jan. 11 19 57

ORM R-301A

INSTRUCTIONS FOR EDICAL CERTIFICATE

In giving AUSE OF DEATH

do not enter more than one cause for each f (a), (b) and (c)

This does not mean mode of dying, h as heart failure, henia, etc. It means disease, or compli- ions which caused ath.

Conditions, if any, which gave rise to bove cause (a), tating the under- ying cause last.

Conditions contrib- ng to death but not ated to the terminal ease condition given (a).

Note:- Chapter 137, cts of 1954, requires aysicians to print or pe the cause or uses of death on ath certificates.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent. 2

Registered No. _____

1 PLACE OF DEATH: Worcester (County); Fayville (City or Town)

No. Woodland Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Homer W. BLANCHARD
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) _____

(a) Residence. No. Woodland Road St. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 7 years ____ months ____ days. In place of residence 7 years ____ months ____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 2 (Day) 1957 (Year)

4 I HEREBY CERTIFY, That I attended deceased from January 29, 1957, to February 2, 1957, last saw him alive on February 2, 1957, death is said to have occurred on the date stated above, at 9:35 p. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Metastatic Cancer	5 yrs.
Due To (b) CANCER OF PROSTATE	5 yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS —	

Was autopsy performed? no
What test confirmed diagnosis? operation

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify —

(Signed) Timothy P. Stone, M. D.
(Address) Main St, Southboro Date Feb. 3 1957

6 Main St. Cemetery Hudson
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Feb/ 4 1957

7 NAME OF FUNERAL DIRECTOR John A. Kennedy
ADDRESS 1 Pleasant St., Hudson

Received and filed Feb 5, 1957 19____
Austin E Kelly (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced HUSBAND of Myrtle (Mace) BLANCHARD
(Give maiden name of wife in full)
(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 7 Months 8 Days — If under 24 hours ____ Hours ____ Minutes

13 Usual Occupation: Machinist
(Kind of work done during most of working life)

14 Industry or Business: Wheatly Machine Co.

15 Social Security No. 034-10-2982

16 BIRTHPLACE (City) Worcester (State or country) Massachusetts

PARENTS

17 NAME OF FATHER: William Blanchard

18 BIRTHPLACE OF FATHER (City) Canada (State or country)

19 MAIDEN NAME OF MOTHER: Delva Toupin

20 BIRTHPLACE OF MOTHER (City) Canada (State or country)

21 Informant (Address) Myrtle (Mace) Blanchard, Woodland Rd., Fayville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) Feb 3, 1957 (Date of Issue of Permit)

30M-5-56-917573

ORM R-301

INSTRUCTIONS FOR EDICAL CERTIFICATE

In giving AUSE OF DEATH

do not enter more than one cause for each f (a), (b) and (c)

This does not mean e mode of dying, ch as heart failure, thenia, etc. It means e disease, or compli-tions which caused ath.

Conditions, if any, which gave rise to above cause (a), stating the under-lying cause last.

Conditions contrib-ting to death but not elated to the terminal isease condition given (a).

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 230

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. White Bagley Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Southboro (City or Town making this return)

2 FULL NAME John Adamson (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW 1

(a) Residence. No. White Bagley Road St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 7 years ... months ... days. In place of residence 7 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Feb (Month) 7 (Day) 1957 (Year)

4 I HEREBY CERTIFY, That I attended deceased from February 19, 1950, to February 7, 1957

I last saw him alive on December 19, 1956, death is said to have occurred on the date stated above, at 10:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Pulmonary Edema	12 hrs
Due To (b) Cardiac Failure	5 mos
Due To (c) Valvular Heart Disease ? Rheumatic	7 yrs plus
OTHER SIGNIFICANT CONDITIONS: Prostatism, Hydronephrosis, Uremia	2 yrs

Was autopsy performed? no

What test confirmed diagnosis? Clinical, X-ray, Therapeutic

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify ...

(Signed) Timothy P. Stone, M. D.

(Address) Main St, Southboro Date Feb 8 1957

6 Rural Cemetery Southboro, Mass (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL Feb. 9, 1957

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro Mass

Received and filed Feb 11 1957 19...

Austin J. Kelly Town Clerk (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
M	White	Married

10a If married, widowed, or divorced HUSBAND of Marjorie A Wilbur (Give maiden name of wife in full)

(or) WIFE of ... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 61 Years 9 Months 20 Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Manufacturer (Kind of work done during most of working life)

14 Industry or Business: Maker of Artifical Flowers

15 Social Security No. 020-28-9577

16 BIRTHPLACE (City) Maynard (State or country) Mass

PARENTS

17 NAME OF FATHER Olaf Adamson

18 BIRTHPLACE OF FATHER (City) ... (State or country) Finland

19 MAIDEN NAME OF MOTHER Margreta Newhouse

20 BIRTHPLACE OF MOTHER (City) ... (State or country) Finland

21 Informant Marjorie (Wilbur) Adamson (Address) White Bagley Rd Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent Bd of Health (Official Designation) 2/8/57 (Date of Issue of Permit)

100M-11-55-916145

EXTRACTS
FROM THE LAWS OF THE
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead.....— General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE Oct. 5, 1917

DATE OF DISCHARGE July 15, 1919

RANK, RATING Corporal

ORGANIZATION AND OUTFIT Prov. Supply Train

SERVICE NUMBER 1 666 750

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

4

1 PLACE OF DEATH: Middlesex (County) — Framingham (City or Town)

Framingham (City or town making return)

Registered No. .....

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Girl Readio
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Southville Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....1.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 12, 1957
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 2-12, 19 57, to 2-12, 19 57

I last saw her alive on 2-12, 19 57, death is said to have occurred on the date stated above, at 11:01A m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Atelactasis

ANTE CEDENT CAUSES Due To (b) Prematurity

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS Separation of Placenta

Major findings:
Of operations.....

Date of operation.....Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....

(Signed) Thomas Paull, M.D. M. D.
(Address) Framingham, Mass. Date 2-13-57 19

6 Maplewood Cem., Marlboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Feb. 14, 1957 19

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Southboro, Mass.

Received and filed Feb 28, 1957 19

Wilson E. Kelley
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE.....Years.....Months...1...Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation:.....
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Framingham
(State or country) Mass.

PARENTS

17 NAME OF FATHER Ellis E. Readio

18 BIRTHPLACE OF FATHER (City) Framingham
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Avonia Williams

20 BIRTHPLACE OF MOTHER (City) Framingham
(State or country) Mass.

21 Informant Ellis E. Readio
(Address) Southville Rd., Southboro

A TRUE COPY
ATTEST: Wm A. Walsh
(Registrar of City or Town where death occurred)

DATE FILED February 21, 1957 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MARLBOROUGH, MASS.
(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. 41

1 PLACE OF DEATH
Middlesex (County)
Marlboro (City or Town)
No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ronald Kevin Burnette
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Newton St. St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 24 (Day) 1957 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 2/24, 1957, to 2/24, 1957

I last saw him alive on 2/24, 1957, death is said to have occurred on the date stated above, at 10:58 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pheumonia — INTERVAL BETWEEN ONSET AND DEATH: 12 Hrs

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No

(Signed) R. A. Johnson, M. D.
(Address) Marlboro, Mass. Date 2/25 1957

6 Rural Cemetery Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL February 26 1957

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass

Received and filed 2/27/57 19....
Raymond D. Lavallee
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Single

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE ..... Years ..... Months 1 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Marlboro
(State or country) Mass.

PARENTS

17 NAME OF FATHER Carlton C. Burnette

18 BIRTHPLACE OF FATHER (City) Roanoke
(State or country) Va.

19 MAIDEN NAME OF MOTHER Grace B. Booth

20 BIRTHPLACE OF MOTHER (City) Framingham
(State or country) Mass.

21 Informant Carlton C. Burnette
(Address) Newton St. Southboro

A TRUE COPY ATTEST: 2-27-57 Raymond D. Lavallee
(Registrar of City or Town where death occurred)

DATE FILED June 26, 1957 19....
Austin E Kelly T.C.

FORM R-303 A

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-3-54-911887

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 230 5

1 PLACE OF DEATH: WORCESTER (County); SOUTHBOROUGH (City or Town); No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ALISON CARTER SAWLER (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR): None

(a) Residence. No. Fay Court (Usual place of abode) St. Southboro, Mass (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 3 months 26 days. In place of residence 2 years 3 months 26 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: MARCH (Month) 7 (Day) 1957 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

FRACT SKULL

5 Accident, suicide, or homicide (specify) ACCIDENT

Date and hour of injury MARCH 7 1957

Where did Injury occur? SOUTHVILLE MASS (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? RAILROAD TRACK (Specify type of place)

Manner of Injury HIT BY LOCOMOTIVE (How did injury occur?)

Nature of Injury FRACT SKULL

While at work? NO Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Mass Date 3-7 1957

7 Rural Cemetery Southboro, Mass. Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL March, 9 1957

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St., Southboro Mass.

Received and filed March 11, 1957 19

Custus E Kelly (Registrar) Town Clerk

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: F

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

11a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 2 Years 3 Months 26 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: at home (Kind of work done during most of working life)

15 Industry or Business: none

16 Social Security No. none

17 BIRTHPLACE (City or Town) Framingham (State or country) Mass

PARENTS

18 NAME OF FATHER Stanley D. Sawler

19 BIRTHPLACE OF FATHER (City) Wakefield (State or country) Mass

20 MAIDEN NAME OF MOTHER Caroline Stilley

21 BIRTHPLACE OF MOTHER (City) Anderson (State or country) Indiana

22 Informant Stanley D. Sawler (Address) Fay Court Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Jimothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) March 8, 1957 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

9

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: Middlesex (County) — Framingham (City or Town) — Framingham (City or town making return)

No. [illegible] Framingham Union Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ruth E. Orzech (nee Henry) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Marlboro Rd St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death.....years.....months 3 days. In place of residence 5 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 19, 1957 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1956, to March 19, 1957

I last saw her alive on March 18, 1957 death is said to have occurred on the date stated above, at 10p m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a)	Carcinoma of sigmoid	
ANTECEDENT CAUSES (b) Due To		3 months
(c) Due To		
OTHER SIGNIFICANT CONDITIONS	Hepatitis	3 mos

Major findings: Of operations.....

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis? examination

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Gertrude H. Lavelle M. D.

(Address) Natick Date 3/21/57 19

6 Rural - Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Marc 23, 1957 19

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro

Received and filed April 9, 1957 19

C. F. Connelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
fe	white	married

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Edward Orzech
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 34 Years 2 Months 4 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At home
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No. 027-14-6844

16 BIRTHPLACE (City) Natick
(State or country) Mass.

PARENTS

17 NAME OF FATHER James M. Henry

18 BIRTHPLACE OF FATHER (City) W. Medway
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Ellen Byrne

20 BIRTHPLACE OF MOTHER (City).....
(State or country) Ireland

21 Informant Edward Orzech
(Address) Southboro

A TRUE COPY
ATTEST: W. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED April 3, 1957 19

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

Note:- Chapter 137, Acts of 1954, requires physicians to print or type the cause or causes of death on death certificates.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 8

1 PLACE OF DEATH: Worcester (County); Southborough (City or Town); No. High Street St. ((If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John W. Dunlop
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. High Street St. Southborough Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 7 years ..... months ..... days. In place of residence 7 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: April (Month) 7 (Day) 1957 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May, 1956, to April, 1957
I last saw him alive on April 7, 1957, death is said to have occurred on the date stated above, at 2 p. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	CEREBRAL VASCULAR ACCIDENT	24 hrs
Due To (b)	ARTERIOSCLEROSIS	4 years
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	CARCINOMA OF PROSTATE	7 years

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Marilyn Mesaros, M. D.
(Address) Parkerville Rd, Southboro Date April 8 1957

6 Mt. Auburn Cambridge, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 10, 1957

7 NAME OF FUNERAL DIRECTOR Irving W. Harper
ADDRESS Westboro, Mass.

Received and filed April 10, 1957
Austin E. Kelly T.C.
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / or DIVORCED (write the word)
Male	White	Widowed

10a If married, widowed, or divorced
HUSBAND of Alice Hall
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 11 Months 15 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Real Estate
(Kind of work done during most of working life)

14 Industry or Business: Own Business

15 Social Security No. 029-26-9068

16 BIRTHPLACE (City) Cambridge
(State or country) Mass.

PARENTS

17 NAME OF FATHER John Dunlop

18 BIRTHPLACE OF FATHER (City) Glascow
(State or country) Scotland

19 MAIDEN NAME OF MOTHER Margaret Campbell

20 BIRTHPLACE OF MOTHER (City) Johnston
(State or country) Scotland

21 Informant Mrs. Robert P. Adams
(Address) Georgetown, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Board of Health (Official Designation) 4/8/57 (Date of Issue of Permit)

10OM-11-55-916145

12

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(c)-11-49-900.475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Marlborough (City or town making return)

Registered No. 102

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town); No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert W. Bates (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) Korean

(a) Residence. No. Newton (Usual place of abode) St. Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 20 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 5 (Day) 1957 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fractured skull

Fractured cervical spines with Braim laceration and shock

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 5/5 1957

Where did Injury occur? Hudson, Mass 12:30 AM (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Washington St. Hudson (Specify type of place)

Manner of Injury Struck tree (How did injury occur?)

Nature of Injury see # 4

While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Arthur G. Richer, M. D.

(Address) Hudson, Mass. Date 5/2/1957

7 Place of Burial, or Cremation, Rural Cemetery Southboro, Mass. (City or Town)

DATE OF BURIAL May 8 1957

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed 5/9/57 19 .....

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: M

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 22 Years 9 Months 9 Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Machinist (Kind of work done during most of working life)

15 Industry or Business: Dorrington Mfg. Co/

16 Social Security No. 032-24-9619

17 BIRTHPLACE (City) (State or country) Framingham Mass.

PARENTS

18 NAME OF FATHER: Chester W. Bates

19 BIRTHPLACE OF FATHER (City) (State or country): Allston Mass.

20 MAIDEN NAME OF MOTHER: Kimetia Hawthorne

21 BIRTHPLACE OF MOTHER (City) (State or country): Brockton, Mass.

22 Informant Mrs. Kimetia Bates
(Address) Newton St. Southboro, Mass

A TRUE COPY.
ATTEST: Raymond D. Lavallee (Registrar of City or Town where death occurred)

DATE FILED June 26, 1957 19 .....

Austin E Kelly Town Clk

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(c)-11-49-900.475

13

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Marlborough (City or town making return)

Registered No. 101

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Donald R. Mitchell (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Parker St. St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 20 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 5 (Day) 1957 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fractured neck, troumotic and central nervous systems, shock

5 Accident, suicide, or homicide (specify) accident

Date and hour of injury 12;13 5/5/ 19 57

Where did Injury occur? Hudson, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Washington, St. Hudson, Mass. (Specify type of place)

Manner of Injury Struck tree (How did injury occur?)

Nature of Injury see # 4

While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Arthur G. Richer, M. D.

(Address) Hudson, Mass. Date 5/7/ 19 57

7 Place of Burial, or Cremation Rural Cemetery Southboro, Mass. (City or Town)

DATE OF BURIAL May 8 19 57

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed 5/9/ 19 57

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: M

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 21 Years 4 Months 8 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Carpenter (Kind of work done during most of working life)

15 Industry or Business: Contractor

16 Social Security No. 021 28 8236

17 BIRTHPLACE (City) (State or country) Framingham Mas

PARENTS

18 NAME OF FATHER William G. Mitchell Dec ease

19 BIRTHPLACE OF FATHER (City) (State or country) Boston, Mass,

20 MAIDEN NAME OF MOTHER Dorothy Frye

21 BIRTHPLACE OF MOTHER (City) (State or country) Beverly, Mass.

22 Informant (Address) Mrs. Dorothy (Frye) Mitche Parker St Southboro, Mass.

A TRUE COPY.
ATTEST: Raymond D. Lavallee (Registrar of City or Town where death occurred)

DATE FILED June 26, 1957 19 .....

Austin E Kelly Town clerk

10

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Westborough
(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH
Worcester (County)
Westborough (City or Town)
No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Isaac Del Castello
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Marlboro Rd. St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death - years 2 months 15 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 12, (Day) 1957 (Year)

I HEREBY CERTIFY, That I attended deceased from Feb. 1m., 19 57 to May 11 19 57

I last saw h... alive on May 11 19 57, death is said to have occurred on the date stated above, at 7:00 a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of the Esophagus — INTERVAL BETWEEN ONSET AND DEATH: yrs

Due To
(b) .....

Due To
(c) .....

OTHER SIGNIFICANT CONDITIONS: Arteriosclerosis; Emaciation — yrs mos.

Was autopsy performed? .....
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Jose J. Llinas M. D.
(Address) Westboro, Mass. Date 5/12/ 19 57

6 Immaculate Conception, Marlboro, Mass.
Place of Burial or Cremation May 15, (City or Town) 57
DATE OF BURIAL ..... 19 .....

7 NAME OF FUNERAL DIRECTOR John J. Brown & Son
ADDRESS Marlboro, Mass.

Received and filed June 12, 1957 19 .....
(Registrar of City or Town where deceased resided) Annie A. Dunne

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE / MARRIED / WIDOWED / or DIVORCED (write the word): Married

10a If married, widowed, or divorced HUSBAND of Mary Santella
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 11 Months 8 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Laborer
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. 034-16-6198

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Carlo Del Castello

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Consiglia Trilli

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant (Address) Westborough State Hospital Clinical Records

A TRUE COPY
ATTEST: Annie A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED May 15, 19 57

FORM R-301

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 11

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — (City or Town making this return)

No. Main Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Delia Ledoux (Robert) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 51 Washington St. Marlboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ... years 1 months 15 days. In place of residence ... years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: JUNE (Month) 25 (Day), 1957 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 14, 1953, to June 25, 1957

I last saw her alive on JUNE 23, 1957, death is said to have occurred on the date stated above, at 11:45 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

Due To (b) —

Due To (c) —

OTHER SIGNIFICANT CONDITIONS: Coronary Thrombosis — 6 weeks
Terminal Uremia — 4 days

Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify —

(Signed) Timothy P. Stone, M. D.
(Address) Main St, Southboro Date June 25 1957

6 St. Mary's Cemetery Marlboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 28, 1957

7 NAME OF FUNERAL DIRECTOR John P. Rowe
ADDRESS Marlboro.

Received and filed June 26, 1957 19
Austin E. Keefe (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of Alfred Ledoux (Husband's name in full) (Give maiden name of wife in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years 4 Months 13 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. —

16 BIRTHPLACE (City) (State or country) Worcester Mass

PARENTS

17 NAME OF FATHER Damien Robert

18 BIRTHPLACE OF FATHER (City) (State or country) Canada

19 MAIDEN NAME OF MOTHER Marcelline LaFreniere

20 BIRTHPLACE OF MOTHER (City) (State or country) Canada

21 Informant Henry Ledoux
(Address) 51 Washington St Marlboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) 6/25/57. (Date of Issue of Permit)

100M-11-55-916145

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

15

Boston (City or Town making this return)

Registered No. 7106

1 PLACE OF DEATH

Suffolk (County)

Boston (City or Town)

No. Mass. Eye and Ear Infirmary St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Herbert Pierce
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. R.F.D. #2 Cordaville Road St. Southboro Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months 21 days. In place of residence 3 years 6 months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 30/57
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 6, 1957, to July 30, 1957
I last saw him alive on July 30, 1957, death is said to have occurred on the date stated above, at 1 AM m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Carcinoma of larynx — 2 Yrs

Due To (b) Laryngectomy — 12 Days

Due To (c) Auricullar fibrillation rt. bundle branch block — ?

OTHER SIGNIFICANT CONDITIONS Non toxic goitre — 40 Yrs

Was autopsy performed? No
What test confirmed diagnosis? biopsy

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) A S Woodward, M. D.
(Address) Mass. Eye & Ear Date 7-30 1957

6 Place of Burial or Cremation Jeffersonville Cem-Jeffersonville vermont (City or Town)
DATE OF BURIAL August 2/57 19

7 NAME OF FUNERAL DIRECTOR Short & Williamson Inc.
ADDRESS Allston Mass.

Received and filed Sept 6, 1957
(Registrar of City or Town where deceased resided) by Town Clerk

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M

9 COLOR: W

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced HUSBAND of Jessie C Buker
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years 2 Months 16 Days — If under 24 hours Hours Minutes

13 Usual Occupation: Manager Retired
(Kind of work done during most of working life)

14 Industry or Business: Creamery

15 Social Security No. ----

16 BIRTHPLACE (City) (State or country) Whiting Vermont

PARENTS

17 NAME OF FATHER Eugene Pierce

18 BIRTHPLACE OF FATHER (City) (State or country) Whiting Vermont

19 MAIDEN NAME OF MOTHER Marion Thresher

20 BIRTHPLACE OF MOTHER (City) (State or country) Crown Point New York

21 Informant (Address) Mrs Arlene J Odell R.F.D. #2 Cordaville Rd. Southboro Mass.

A TRUE COPY Charles H. Mackie
ATTEST:
(Registrar of City or Town where death occurred)

DATE FILED August 5/57 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

WORCESTER
(City or Town making this return)

Registered No. 19

1 PLACE OF DEATH
WORCESTER (County)
WORCESTER (City or Town)
No. The Memorial Hospital St. ((If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jeannette (Moore) Harvey
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Worcester Rd. St. Southboro, Mass.
(Usual place of abode) 1 month 29 days 23 hours (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept 6, 1957
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 7/8 er, 1957, to 9/6, 1957
I last saw h alive on 9/6, 1957, death is said to have occurred on the date stated above, at 4:10 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute Nephropathy cortical necrosis	2days
Due To (b) Malignant Hypertension	2yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Cardiac Hypertrophy	1yr

Was autopsy performed? yes
What test confirmed diagnosis? -

5 Was disease or injury in any way related to occupation of deceased? -
If so, specify .....

(Signed) Samuel C. Pickens, M. D.
(Address) 119 Belmont St Date 9/6 1957

6 Woodside Middletown Ohio
Place of Burial or Cremation (City or Town)
DATE OF BURIAL September 10 1957

7 NAME OF FUNERAL DIRECTOR Carl G Nordgren
ADDRESS 49 Belmont St., Worcester

Received and filed October 11, 1957
(Registrar of City or Town where deceased resided) T. C.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	Black	Married

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Matthew Harvey
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 28 Years - Months - Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) Kirksville
(State or country) Kentucky

PARENTS

17 NAME OF FATHER Richard Moore

18 BIRTHPLACE OF FATHER (City) - - -
(State or country) Kentucky

19 MAIDEN NAME OF MOTHER Mary (Unknown)

20 BIRTHPLACE OF MOTHER (City) - - -
(State or country) Kentucky

21 Informant (Address) Jordan Hall Funeral Home Middletown, Ohio

A TRUE COPY
ATTEST: Robert J. O'Keefe
(Registrar of City or Town where death occurred)

DATE FILED September 9 1957

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M (D)-12-49-900722

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 16

1 PLACE OF DEATH
~~Worcester~~ ~~Middlesex~~ (County)
South boro (City or Town)
No. Town Hall St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ######## JOHN R. FOLEY
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 20 Wood Terrace St. Framingham, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 9 (Month) 21 (Day) 57 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Acute coronary occlusion

5 Accident, suicide, or homicide (specify) no
Date and hour of injury ..... 19 .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury ..... (How did injury occur?)
Nature of Injury .....
While at work? No Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Kenneth R. Greenleaf, M. D.
(Address) Marlboro Date 9/24 19 57

7 St. Stephens Cemet. Framingham
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL Sept. 24, 1957 19 .....

8 NAME OF FUNERAL DIRECTOR John A. Cunningham
ADDRESS Framingham

Received and filed Sept 25, 1957 19 .....
Caroline F. Kelly (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	W	SINGLE

11a If married, widowed, or divorced
HUSBAND of ..... none (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 72 Years 2 Months 11 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Menu Printer (Kind of work done during most of working life)

15 Industry or Business: Hotel Work

16 Social Security No. 262-05-6717

17 BIRTHPLACE (City) Framingham (State or country)

PARENTS

18 NAME OF FATHER John Foley

19 BIRTHPLACE OF FATHER (City) Ireland (State or country)

20 MAIDEN NAME OF MOTHER Catherine Flynn

21 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

22 Informant Mary E. McGrath
(Address) 20 Wood Terrace Framingham

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Horne MD
(Signature of Agent of Board of Health or other)
Agent Bd of Health 9-23-57
(Official Designation) (Date of Issue of Permit)

P13.4

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

FRAMINGHAM
(City or town making return)

Registered No. 17.

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Mc Clard
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Atwood Rd. St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 5 days. In place of residence 11 years 11 months 2 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 21, 1957
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 9/17/ 57, to SEpt. 21 57

I last saw h im alive on 9/21/57, death is said to have occurred on the date stated above, at 2:15A m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Acute Lymphatic Leukemia

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Cerebrovascular accident.

Major findings:
Of operations.....
Date of operation..... Was autopsy performed?.....
What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? NO.
If so, specify.....
(Signed) Melvin Gordon M. D.
(Address) 132 Lincoln St. Framingham, Mass. Date 9/22/57

6 Rural Cem. Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Sept. 24, 1957

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass.

Received and filed Sept 26, 1957 19....

Alice F. Kidd
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 11 Years 11 Months 2 Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: School Student
(Kind of work done during most of working life)

14 Industry or Business: School

15 Social Security No.....

16 BIRTHPLACE (City) (State or country) Framingham, Mass.

PARENTS

17 NAME OF FATHER Durward Mc Clard

18 BIRTHPLACE OF FATHER (City) Advance, (State or country) Mo.

19 MAIDEN NAME OF MOTHER Ann Cummings

20 BIRTHPLACE OF MOTHER (City) Westboro, (State or country) Mass.

21 Informant Durward Mc Clard
(Address) Atwood Rd., Southboro, Mass

A TRUE COPY
ATTEST: W. A. Walsh
(Registrar of City or Town where death occurred)

DATE FILED Sept. 26 19 57

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Boston
(City or Town making this return)

Registered No. 8981 21

1 PLACE OF DEATH

Suffolk
(County)

Boston
(City or Town)

No. Boston Lying In Hospt. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Boy Morse Twin #1
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. R.F.D. Gilmore Road St. Southboro Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 30/57
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 30 19 57 to Sept. 30, 19 57
I last saw him alive on Sept. 30, 19 57 death is said to have occurred on the date stated above, at 10:29PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary atelectasis

Due To (b) Prematurity

Due To (c)

OTHER SIGNIFICANT CONDITIONS Cardiac failure due to hypervolemia

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? Yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Luke Gillespie, M. D.
(Address) 1180 Beacon St. Brookline Date 10-1-57 19

6 Forest Hills Cem-Boston Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Oct. 2/57 19

7 NAME OF FUNERAL DIRECTOR J S Waterman & Sons
ADDRESS Boston Mass.

Received and filed Oct-15/1957 19
Austin S Kelly.
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
M	W	Single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE Years Months Days — If under 24 hours 7 Hours 53 Minutes

13 Usual Occupation: ——— (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Boston Mass.

PARENTS

17 NAME OF FATHER Donal F Morse

18 BIRTHPLACE OF FATHER (City) (State or country) Cambridge Mass.

19 MAIDEN NAME OF MOTHER Carol T Tupy

20 BIRTHPLACE OF MOTHER (City) (State or country) Chicago Illinois

21 Informant (Address) Boston Lying In Hospt Boston Mass.

A TRUE COPY
ATTEST: Charles H. Mackie
(Registrar of City or Town where death occurred)

DATE FILED Oct. 3/57 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Boston
(City or Town making this return)

Registered No. 8982

1 PLACE OF DEATH

Suffolk
(County)

Boston
(City or Town)

No. Boston Lying In Hospt. St. ((If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Boy Twin #2 Morse
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. R.F.D. Gilmore Road St. Southboro Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 30/57
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 30 /57 to Sept. 30, 1957
I last saw h— alive on Sept. 30 1957, death is said to have occurred on the date stated above, at 2:44 PM m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Intrauterine asphyxia

Due To (b) Prematurity

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? Yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Luke Gillespie M. D.
(Address) 1180 Beacon St. Brookline Mass. Date 10-1 1957

6 Forest Hills Boston Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Oct. 2/57 19

7 NAME OF FUNERAL DIRECTOR J S Waterman & Sons
ADDRESS Boston Mass.

Received and filed Oct 18, 1957 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M

9 COLOR W

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Single

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE Years Months Days | If under 24 hours 8 Hours Minutes

13 Usual Occupation: ——
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Boston Mass.
(State or country)

PARENTS

17 NAME OF FATHER Donal F Morse

18 BIRTHPLACE OF FATHER (City) Cambridge Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Carol L Tupy

20 BIRTHPLACE OF MOTHER (City) Chicago Illinois
(State or country)

21 Informant Boston Lying In Hospt
(Address) Boston Mass.

A TRUE COPY
ATTEST: Charles H. Mackie
(Registrar of City or Town where death occurred)

DATE FILED Oct. 7/57 19

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 14

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Parkerville Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Emilia Brodeur Morin
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Parkerville Rd. St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death 30 years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH [illegible] OCT. 5 1957
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from FEB 4, 1935, to OCT 5, 1957

I last saw her alive on OCT. 5, 1957, death is said to have occurred on the date stated above, at 3 30 A m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	ARTERIO SCLEROTIC HEART DISEASE	10 yrs
ANTECEDENT CAUSES Due To (b)	ASTAMATIC BRONCHITIS	1935
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations .....

Date of operation ..... Was autopsy performed? .....

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Albert E. Le Blanche, M. D.
(Address) Marlboro Date Oct 7 1957

6 Place of Burial or Cremation Rural Cemetery (City or Town) Southboro
DATE OF BURIAL Oct. 7th 1957

7 NAME OF FUNERAL DIRECTOR J. Brisson & Morin
ADDRESS Chestnut St. Marlboro

Received and filed Oct 9, 1957 19 .....
Dorothy F. Kelly (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE / MARRIED / WIDOWED / or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Charles H. Morin (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years 1 Months 10 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At Home (Kind of work done during most of working life)

14 Industry or Business: House Work

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Canada

PARENTS

17 NAME OF FATHER Joseph Brodeur

18 BIRTHPLACE OF FATHER (City) (State or country) Canada

19 MAIDEN NAME OF MOTHER Emeline Osterlee Osterlee

20 BIRTHPLACE OF MOTHER (City) (State or country) Canada

21 Informant Mrs. Chas. Charest
(Address) Parkerville Rd

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) Oct 5, 1957 (Date of Issue of Permit)

50M (B)-1-51 903566

FORM R-303 A

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-3-54-911887

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 230 20

1 PLACE OF DEATH
Worcester (County)
Southborough (City or Town)
No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George Gulbankain
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. ..... St. Cordaville Rd Cordaville Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 50 years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 9-57
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden Death Presumably
Coronory Thrombosis

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury ..... 19 .....
Where did Injury occur? .....
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)
Manner of Injury .....
(How did injury occur?)
Nature of Injury .....
While at work? ..... Was autopsy performed? .....

6 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Walter F Mahoney M. D.
(Address) Westborough Mass Date Oct 10-57 19 .....

7 Rural Cemetery Southboro, Mass
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL October 12, 19 57

8 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro Mass.

Received and filed October 14, 1957 19 .....
Agnes E. Kelly (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX M

10 COLOR OR RACE White

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

11a If married, widowed, or divorced
HUSBAND of Eva Mooradian
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 69 Years 3 Months 2 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Farmer
(Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. 010 30 7100

17 BIRTHPLACE (City) Haput
(State or country) Armenia

PARENTS

18 NAME OF FATHER Mushegh Gulbankian

19 BIRTHPLACE OF FATHER (City) Haput
(State or country) Armenia

20 MAIDEN NAME OF MOTHER Dorothy Demorjian

21 BIRTHPLACE OF MOTHER (City) Haput
(State or country) Armenia

22 Informant Mrs. Eva Gulbankian
(Address) Cordaville Rd Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P Stone
(Signature of Agent of Board of Health or other)
Agent Board of Health
(Official Designation)
Oct 12, 1957
(Date of Issue of Permit)

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-5-52-907046

24

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Westborough
(City or town making return)

Registered No. 223

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town); No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary A. Lefevre
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. (Usual place of abode) St. Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 11, 1957 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Cerebral arteriosclerosis
Fractured hip

5 Accident, suicide, or homicide (specify) accident
Date and hour of injury Oct. 1, 1957
Where did Injury occur? Westborough, Mass. (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? State Hospital (Specify type of place)
Manner of Injury Fall in Bath Room (How did injury occur?)
Nature of Injury Fract. hip
While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Walter F. Mahoney M. D.
(Address) Westborough, Mass. Date 10-10 1957

7 St. Patricks Cem., Whitinsville
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL Oct. 15, 1957

8 NAME OF FUNERAL DIRECTOR Carroll R. Gochie
ADDRESS 390 Main St., Saundersville

Received and filed Nov 7, 1957
Gustave E. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female
10 COLOR OR RACE White
11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Separat

11a If married, widowed, or divorced
HUSBAND of Cannot be learned (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 82 Years 4 Months 13 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Retired (Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No.

17 BIRTHPLACE (City) Thompson, Conn. (State or country)

PARENTS

18 NAME OF FATHER Simon Gervis Javery

19 BIRTHPLACE OF FATHER (City) Canada (State or country)

20 MAIDEN NAME OF MOTHER Mary Rondeau

21 BIRTHPLACE OF MOTHER (City) Canada (State or country)

22 Informant Westborough State Hospital Records (Address)

A TRUE COPY.
ATTEST: Annie A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED Oct. 16, 1957

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 23

1 PLACE OF DEATH
Middlesex (County)
Framingham (City or Town)
No. Framingham UNion Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Christine Malling
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Connors' Rest Home-East Main St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 4 days. In place of residence 50 in Southboro 2 in Resthome years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 21 1957
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1957, to October 21 1957

I last saw her alive on Oct. 21, 1957, death is said to have occurred on the date stated above, at 10:13 P. m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral thrombosis Rt. side	4 days
ANTECEDENT CAUSES Due To (b)	
Due To (c) 1) Pulmonary edema	2 days
2) Pulmonary intarcts	2 days
OTHER SIGNIFICANT CONDITIONS 3) Left lower lobe pneumonia	2days
4) Pyelo nephritis	3 days

Major findings:
Of operations.....
Date of operation..... Was autopsy performed? yes
What test confirmed diagnosis? lumbar puncture

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) Fred M. Pierce, Jr. M. D.
(Address) 25 Evergreen St. Date Oct. 23 1957

6 Rural Cemetery Southboro, Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Oct. 24, 1957

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass.

Received and filed October 24, 1957
Edward F. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	white	Single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years.....Months 27 Days. If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Domestic
(Kind of work done during most of working life)

14 Industry or Business: Home

15 Social Security No.....

16 BIRTHPLACE (City) Denmark
(State or country)

PARENTS

17 NAME OF FATHER Adolf Malling

18 BIRTHPLACE OF FATHER (City) Denmark
(State or country)

19 MAIDEN NAME OF MOTHER (c.n.b.l.) Dubrhn

20 BIRTHPLACE OF MOTHER (City) Denmark
(State or country)

21 Informant (Address) Mrs. C. Ober Main St., Southboro, Mass.

A TRUE COPY
ATTEST: William S. Walsh
(Registrar of City or Town where death occurred)

DATE FILED October 23, 1957

FORM R-301A

24

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. 24 East Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Thomas Armstrong
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. 24 East Main St., St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 45 years ..... months ..... days. In place of residence 45 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires Physicians to print or type the cause or causes of death on death certificates.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 7 (Day) 1957 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1957, to Nov 7, 1957
I last saw him alive on November 6, 1957, death is said to have occurred on the date stated above, at 10:48 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral Thrombosis	3 days
Due To (b) Arteriosclerosis	—
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Cerebrovascular Accident (Cabed since)	15 mos.

Was autopsy performed? no
What test confirmed diagnosis? clinical.

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....

(Signed) Timothy P. Stone, M. D.
(Address) Main St, Southboro Date Nov 8 1957

6 Rural Cemetery, Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Nov. 10, 1957

7 NAME OF FUNERAL DIRECTOR C. Ronald Merriam
ADDRESS Framingham, Mass.

Received and filed Nov 14, 1957 19....
Austin E. Kelly, Jr. (Registrar)

100M-11-55-916145

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced HUSBAND of Isabella Hamilton
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years 7 Months 3 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Farmer
(Kind of work done during most of working life)

14 Industry or Business: Deerfoot Farms, Inc

15 Social Security No. .....

16 BIRTHPLACE (City) County Fernanagh
(State or country) Ireland

PARENTS

17 NAME OF FATHER Robert Armstrong

18 BIRTHPLACE OF FATHER (City) Cannot be learned
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Margaret Bryan

20 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country) Ireland

21 Informant Mrs. Isabella Armstrong
(Address) Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Bd of Health (Official Designation) Nov 8, 1957 (Date of Issue of Permit)

FORM R-301

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 230

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); Southboro (City or town making return)

No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Giannetta GIANNIA
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. ..... (Usual place of abode) Central St Fayville, Mass. St. ..... (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 5 months ..... days. In place of residence ..... years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 8, 1957 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1957, to Nov 8, 1957

I last saw her alive on Oct 9, 1957, death is said to have occurred on the date stated above, at 10 A m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) ARTERIOSCLEROTIS HEART DISEASE	6 mos
ANTECEDENT CAUSES Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS thrombophlebitis	

Major findings: Of operations.....

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis? physical exam

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Marilyn Meserve, M. D.

(Address) Southboro, Mass. Date Nov 8, 1957

6 Cavalry Cemetery New York, N.Y.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 8, 1957

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main ST. Southboro, Mass.

Received and filed Nov 13, 1957. 19.....

Austin E. Kelly Town Clerk
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	White	Widowed

10a If married, widowed, or divorced HUSBAND of Antonio Giannia
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 91 Years 7 Months 13 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Domestic
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No. 089-24-3949

16 BIRTHPLACE (City) Emilia (State or country) Italy

PARENTS

17 NAME OF FATHER could not be learned

18 BIRTHPLACE OF FATHER (City) Italy (State or country)

19 MAIDEN NAME OF MOTHER could not be learned

20 BIRTHPLACE OF MOTHER (City) Italy (State or country)

21 Informant Francis Iessini
(Address) Boston rd, Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) Nov 8, 1957 (Date of Issue of Permit)

100M-(C)-10-48-24658

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Brian R. McLaughlin (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. East Main St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death.....years.....months 4 days. In place of residence 8 years 9 months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 8. 1957
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 4 1957, to Nov. 8 1957

I last saw h.....im alive on Nov. 8, 1957, death is said to have occurred on the date stated above, at 4:30 P m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Pneumococcal meningitis

ANTECEDENT CAUSES Due To (b) .....

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS .....

Major findings: Of operations.....

Date of operation.....Was autopsy performed? no.

What test confirmed diagnosis? Lumbar Puncture

5 Was disease or injury in any way related to occupation of deceased? no.
If so, specify.....
(Signed) Melvin J. Gordon M. D.
(Address) Framingham Date 11/9/ 1957

6 Rural Cemetery, Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL November 11 1957.

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro

Received and filed Nov 20, 1957 19.....

Alice D. Keeley, R.C.
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
male	White	Single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 8 Years 9 Months 8 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Student
(Kind of work done during most of working life)

14 Industry or Business: Grade School

15 Social Security No.....

16 BIRTHPLACE (City) Framingham, (State or country) Mass.

PARENTS

17 NAME OF FATHER Richard G.McLaughlin

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.

19 MAIDEN NAME OF MOTHER Jean Clapp

20 BIRTHPLACE OF MOTHER (City) Framingham, (State or country) Mass.

21 Informant Richard G. McLaughlin
(Address) E.Main St., Southboro

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED November 13, 1957.

FORM R-303 A

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-3-54-911887

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27

To be filed for burial permit with Board of Health or its Agent.

Registered No. 86

1 PLACE OF DEATH: WORCESTER (County); SOUTHBORO (City or Town)

No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John Gardner Alden
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Central (Usual place of abode) St. Southborough (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 1 months 22 days. In place of residence ..... years 1 months 22 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. (Month) 15 (Day) 1957 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

ASPHYXIATION BY SUFFACATION UNDER BED CLOTHING

5 Accident, suicide, or homicide (specify) ACCIDENT

Date and hour of injury NOV 15 19 57

Where did Injury occur? SOUTHBOR MASS (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? AT HOME (Specify type of place)

Manner of Injury SUFFACATION IN CRIB (How did injury occur?)

Nature of Injury ASPHYXIATION

While at work? NO Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased? NO

If so, specify .....

(Signed) evelin F Mahoney M. D.

(Address) 6 W Main St Westborough Date Nov 15 19 57

7 Rural Cemetery Southboro, Mass
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Nov. 15, 1957 19

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed November 15, 1957 19

Quentin E Kelly (Registrar) T. C.

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: M

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE Years 1 Months 22 Days | If under 24 hours Hours ..... Minutes

14 Usual Occupation: Infant (Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. .....

17 BIRTHPLACE (City) Framingham (State or country) Mass

PARENTS

18 NAME OF FATHER Gardner Alden

19 BIRTHPLACE OF FATHER (City) Framingham (State or country) Mass

20 MAIDEN NAME OF MOTHER Virginia Dyer

21 BIRTHPLACE OF MOTHER (City) Framingham (State or country) Mass

22 Informant Gardner Alden
(Address) John St. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Linus T. P. Stone
(Signature of Agent of Board of Health or other)

Agent Bd of Health (Official Designation) Nov 15 1957 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

29

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Milford (City making this return)

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Milford (City or Town); No. Milford Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME - --- Harrington (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. Prentice St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death - years - months - days. In place of residence - years - months - days. 4½ hrs.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 16 (Day) 1957 (Year)

4 I HEREBY CERTIFY, That I attended deceased from November 16, 57, to November 16, 1957

I last saw him alive on November 16, 1957, death is said to have occurred on the date stated above, at 8:45p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH 4½hrs.

Due To (b) Prematurity 7 mos. -

Due To (c) - -

OTHER SIGNIFICANT CONDITIONS -

Was autopsy performed? -

What test confirmed diagnosis? -

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Jacob Sheinkopf, M. D.

(Address) Medway, Mass. Date 11/16 1957

6 St. Patrick Cemetery Natick (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL November 19 1957

7 NAME OF FUNERAL DIRECTOR John Everett & Sons

ADDRESS Park St., Natick

Received and filed NOV 21 1957 19.....

Quentin E. Kelley, T. C. (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male | 9 COLOR: White | 10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE - Years - Months - Days | If under 24 hours 4 Hours 30 Minutes

13 Usual Occupation: - (Kind of work done during most of working life)

14 Industry or Business: -

15 Social Security No. -

16 BIRTHPLACE (City) Milford (State or country) Mass.

PARENTS

17 NAME OF FATHER Henry Harrington

18 BIRTHPLACE OF FATHER (City) Haverhill (State or country) Mass.

19 MAIDEN NAME OF MOTHER Mary Lane

20 BIRTHPLACE OF MOTHER (City) Quincy (State or country) Mass.

21 Informant Ellen Lane
(Address) Woodland St., Natick, Mass.

A TRUE COPY
ATTEST: Catherine L. Coyne
(Registrar of City or Town where death occurred)

DATE FILED November 19 1957

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 20

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Peter Boselli (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Breakneck Hill Rd. St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ..... years ..... months 10 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 17, 1957 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1957, to Nov. 17, 1957.

I last saw him alive on Nov. 16, 1957, death is said to have occurred on the date stated above, at 9:00 P.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Carcinoma esophagus	3 mos. plus
ANTECEDENT CAUSES Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Aspiration pneumonia terminal	

Major findings: Of operations .....

Date of operation ..... Was autopsy performed? no.

What test confirmed diagnosis? X-ray

5 Was disease or injury in any way related to occupation of deceased? no.

If so, specify .....

(Signed) Timothy P. Stone M. D.

(Address) Main St. Southboro Date 11/18 19 57

6 Rural Cemetery Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 20 1957

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St., Southboro

Received and filed Nov. 27, 1957

Dorothy Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	widowed

10a If married, widowed, or divorced HUSBAND of Mary Domenica Cassinari (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 11 Months 14 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Caretaker (Kind of work done during most of working life)

14 Industry or Business: Groundskeeper

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Montecleraro Italy

PARENTS

17 NAME OF FATHER Jackimo Boselli

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER C.N.B.L.

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Paul Boselli
(Address) Pleasant St. Fayville, Mass

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED Nov. 20, 1957.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. 31

1 PLACE OF DEATH

Middlesex (County)

Framingham (City or Town)

No. Framingham Nursing Home St. 517 Winter St.
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles Jones
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Cottage St. St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 1 months ..... days. In place of residence 45 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 23, 1957
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1950, to Nov. 23, 1957

I last saw him alive on 11/22/57, 19....., death is said to have occurred on the date stated above, at 8:45 A.m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cerebral thrombosis	2 das.
ANTECEDENT CAUSES Due To (b)	Arteriosclerosis	Years
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Prostatism	

Major findings:
Of operations.....
Date of operation..... Was autopsy performed? No.
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? no.
If so, specify.
(Signed) Timothy P. Stone M. D.
(Address) Main St. Southboro Date 11/23/57, 19

6 Rural Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Nov. 26, 1957, 19

7 NAME OF FUNERAL DIRECTOR William M. Tighe
ADDRESS 3 Windso St., Marlboro

Received and filed Nov. 27, 19 57
Walter E. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced
HUSBAND of Susie Bowker
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 90 Years 5 Months 22 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired Wool spinner
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Chelmsford, Mass.
(State or country)

PARENTS

17 NAME OF FATHER Thomas zJones

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER Jane Glass

20 BIRTHPLACE OF MOTHER (City) England
(State or country)

21 Informant *(wife)
(Address) Cottage St. Southboro

A TRUE COPY
ATTEST: W. A. Walsh
(Registrar of City or Town where death occurred)
Nov. 25, 1957
DATE FILED ..... 19.....

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH

Plymouth (County)

Brockton (City or Town)

No. Brockton Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Brockton (City or Town making this return)

2 FULL NAME Nellie (Campbell) Harding
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify, WAR) .....

(a) Residence. No. East Main St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 7 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 3, 1957
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1957 to Dec. 3, 1957

I last saw h alive on Dec. 3, 1957 death is said to have occurred on the date stated above, at 9:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Malignant Lymphoma probably Hodgkin's Sarcoma

Due To
(b) .....

Due To
(c) .....

OTHER SIGNIFICANT CONDITIONS Bladder Calculus

Was autopsy performed? -
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? -
If so, specify .....

(Signed) P.C.Jaena, M. D.
(Address) Brockton Hospital Date Dec.3, 1957

6 Woodlawn Cemetery - Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 6, 1957

7 NAME OF FUNERAL DIRECTOR David Fudge & Son, Inc.
ADDRESS 100 Highland Ave., Somerville

Received and filed Jan 16, 1958
(Registrar of City or Town where deceased resided) Cecelia E. Kelly T.C.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Roy A.Harding
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years 9 Months 28 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housework
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Cambridge, Mass.

PARENTS

17 NAME OF FATHER Thomas R.Campbell

18 BIRTHPLACE OF FATHER (City) (State or country) Cannot be learned

19 MAIDEN NAME OF MOTHER Bessie L.Waterman

20 BIRTHPLACE OF MOTHER (City) (State or country) Bridgewater, N.S.

21 Informant Roy A.Harding Mass.
(Address) East Main St., Southboro.

A TRUE COPY
ATTEST: John B. Clifford
(Registrar of City or Town where death occurred)

DATE FILED Dec. 6, 1957

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-8-56-918227

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

2

Registered No. 1802

1 PLACE OF DEATH: Middlesex (County); Cambridge (City or Town); Cambridge (City or Town making this return)

No. Mount Auburn Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret Reynolds Starratt (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) ---

(a) Residence. No. Pearl St. St. Southville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ... years ... months 1 days. In place of residence 3 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 11, 1957 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 10th, 1957, to Dec. 11th, 1957

I last saw her alive on Dec. 10th 1957 death is said to have occurred on the date stated above, at 6:15a. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Coronary Thrombosis	2 days
Due To (b)	Arterio Sclerosis	
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? no
What test confirmed diagnosis? clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Frank J. Fleming, M. D.
(Address) 333 Trapelo Rd. Belmont Date Dec. 11 19 57

6 Place of Burial or Cremation Highland Cemetery (City or Town) Norwood, Mass.
DATE OF BURIAL Dec. 13, 19 57

7 NAME OF FUNERAL DIRECTOR Short & Williamson, Inc.
ADDRESS Desire W. Williamson Belmont, Mass.

Received and filed Jan 10, 1958 19
(Registrar of City or Town where deceased resided)
Austin E. Kelly, T.C.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of --- (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 88 Years 3 Months 1 Days | If under 24 hours Hours Minutes

13 Usual Occupation: Retired Executive Secretary (Kind of work done during most of working life)

14 Industry or Business: Institutional

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) St. John New Brunswick

PARENTS

17 NAME OF FATHER Alfred L. Starratt

18 BIRTHPLACE OF FATHER (City) (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Louise Reynolds

20 BIRTHPLACE OF MOTHER (City) (State or country) St. John New Brunswick

21 Informant Mrs. Carolyn W. Howard-Neice
(Address) McLean Hospital, Belmont, Mass

A TRUE COPY Frederick H. Burke
ATTEST: (Registrar of City or Town where death occurred)

DATE FILED December 12, 19 57

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough 3
(City or Town making this return)

Registered No. .....

1 PLACE OF DEATH
Middlesex (County)
Marlborough, Mass (City or Town)
No. Marlborough Hospital St. ((If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Adomones, Walter (Walter Adamonis)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. Main Street Southboro, Mass. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 0 days. In place of residence 9 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 21, 1957
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 25 '49 to Dec. 21 '57
I last saw him alive on Dec. 21 1957 death is said to have occurred on the date stated above, at 2:05 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Pneumonia, type undetermined	less than 24 hrs.
Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Arteriosclerotic Heart Disease	10 yrs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical Examination

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signed) Timothy P. Stone, M. D.
(Address) Main St., Southboro Date Dec. 21 1957

6 St. Francis Cemetery, Pawtucket, R.I.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 24, 1957

7 NAME OF FUNERAL DIRECTOR Russell J. Boyle, 274
ADDRESS 331 Smith Street, Providence R.I.

Received and filed Jan 15, 1958 19 58
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Widowed

10a If married, widowed or divorced
HUSBAND of ? (Sophie ?)
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years 5 Months 22 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Maintanance Man
(Kind of work done during most of working life)

14 Industry or Business: Fays School, Southboro, Mass

15 Social Security No. .....

16 BIRTHPLACE (City) Lithuania
(State or country)

PARENTS

17 NAME OF FATHER ? ?

18 BIRTHPLACE OF FATHER (City) Lithuania
(State or country)

19 MAIDEN NAME OF MOTHER ? ?

20 BIRTHPLACE OF MOTHER (City) Lithuania
(State or country)

21 Informant Jean Kupka
(Address) 139 Orms Street, Providence 8, R.I.

A TRUE COPY
ATTEST: Raymond D. Lavallee
(Registrar of City or Town where death occurred)

DATE FILED December 27, 1957

50M-11-55-916145

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham 4
(City or town making return)

Registered No. .....

1 PLACE OF DEATH
Middlesex (County)
Framingham (City or Town)
No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Annie Neary (nee: Spaulding)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. School St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 5 days. In place of residence 12 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 8, 1958
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1948, to Jan. 8, 1958

I last saw her alive on Jan. 8, 1958 death is said to have occurred on the date stated above, at 3:10 P m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Pneumonia, L.L.L. Lobar	5 das.
ANTECEDENT CAUSES Due To (b) recurrent pneumonia aspiration	years
Due To (c) Esophageal stricture	46 years
OTHER SIGNIFICANT CONDITIONS Bronchiectasio, right	years

Major findings:
Of operations .....
Date of operation ..... Was autopsy performed? Yes.
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify .....
(Signed) Timothy P. Stone M. D.
(Address) Main St. Southboro Date 1/10/ 1958

6 Edwards Cem. Framingham
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan. 11, 1958

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St., Southboro

Received and filed Jan 20 1958 19....
Walter E. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Married

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Charles W. Neary
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 11 Months 22 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home.

15 Social Security No. None

16 BIRTHPLACE (City) Brattleboro Vermont
(State or country)

PARENTS

17 NAME OF FATHER Charles Spaulding

18 BIRTHPLACE OF FATHER (City) .....
(State or country) Canada

19 MAIDEN NAME OF MOTHER Abbie Swan

20 BIRTHPLACE OF MOTHER (City) Cannot be learned.
(State or country)

21 Informant Charles W. Neary
(Address) School St., Southboro

A TRUE COPY
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED January 15, 1958.

ORM R-303 A

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATE.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

25M-3-54-911887

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 86

1 PLACE OF DEATH: Worcester (County); Southborough (City or Town); No. Deerfoot Farms Meat Packing Plant St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Evaristo J Carloni (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. Newton St. Southboro Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 50 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 23 (Day) 1958 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden Death Prrsumably Coronory Thrombosis

5 Accident, suicide, or homicide (specify)

Date and hour of injury ....19....

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Mass Date I-24 1958

7 Rural Cemetery Southboro Mass. Place of Burial, or Cremation? (City or Town)

DATE OF BURIAL Jan 27, 1958 19....

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro Mass

Received and filed Jan 27, 1958 19....

Clinton E Keefe Jr. T C (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: M

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

11a If married, widowed, or divorced
HUSBAND of Maria Nicolini (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 67 Years 7 Months 24 Days | If under 24 hours ....Hours....Minutes

14 Usual Occupation: Meatcutter (Kind of work done during most of working life)

15 Industry or Business Deerfoot Meat Plant

16 Social Security No. 029-03-5171

17 BIRTHPLACE (City) Fasano (State or country) Italy

PARENTS

18 NAME OF FATHER Angelo Carloni

19 BIRTHPLACE OF FATHER (City) cnbl (State or country) Italy

20 MAIDEN NAME OF MOTHER Fulvia Bartoluccio

21 BIRTHPLACE OF MOTHER (City) CNBL (State or country) Italy

22 Informant Miss Lena Carloni (Address) Newton St. Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) Jan 26, '58 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

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50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 6

1 PLACE OF DEATH: Middlesex (County); Marlboro (City or Town); Marlboro (City or Town making this return)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Bridget Lucy O'Connell (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Fisher Road St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ..... years ..... months 12 days. In place of residence 81 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 19 1958 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1958 to Feb. 19, 1958

I last saw her alive on Feb. 19, 1958, death is said to have occurred on the date stated above, at 6:30 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 11 days

Due To (b) Gen. Arteriosclerosis — 20 yrs.

Due To (c)

OTHER SIGNIFICANT CONDITIONS No

Was autopsy performed? .....
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) Raymond A. Johnson M. D.
(Address) Marlboro, Mass. Date Feb. 20 1958

6 Immaculate Conception, Marlboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Feb. 22, 1958

7 NAME OF FUNERAL DIRECTOR William M. Tighe
ADDRESS 3 Windsor St., Marlboro

Received and filed March 3 1958
Austin E. Kelly,
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At home (Kind of work done during most of working life)

14 Industry or Business: -

15 Social Security No. -

16 BIRTHPLACE (City) Southboro (State or country) Mass.

PARENTS

17 NAME OF FATHER David O'Connell

18 BIRTHPLACE OF FATHER (City) Ireland (State or country)

19 MAIDEN NAME OF MOTHER Hannah Toomey

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant (Address) Margaret O'Connell (sister) Fisher Rd., Southboro, Mass.

A TRUE COPY
ATTEST: Raymond D. Lavallee
(Registrar of City or Town where death occurred)

DATE FILED February 20, 1958

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-10-53-910621

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 86 7

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. East Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME GRACE FAY BARKER
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. East Main St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 years ... months ... days. In place of residence 3 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH (Month) 6 (Day) 1958 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

SUDDEN DEATH PRESUMABLY CORONARY THROMBOSIS

5 Accident, suicide, or homicide (specify) ...
Date and hour of injury ... 19...
Where did Injury occur? ... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ... (Specify type of place)
Manner of Injury ... (How did injury occur?)
Nature of Injury ...
While at work? NO Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased? NO
If so, specify ...
(Signed) Walter J Mahoney, M. D.
(Address) WESTBOROUGH MASS Date 3-6 1958

7 Rural Cemetery Southboro
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL March, 8 1958

8 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass

Received and filed March 10 1958
Quentin E Kelly Town Clerk. (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	White	Single

11a If married, widowed, or divorced
HUSBAND of ... (Give maiden name of wife in full)
(or) WIFE of ... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 67 Years 5 Months 6 Days | If under 24 hours ... Hours ... Minutes

14 Usual Occupation: Teacher & Principal (Kind of work done during most of working life)

15 Industry or Business: Whitinsville School

16 Social Security No. None

17 BIRTHPLACE (City) (State or country) Marlboro, Mass

PARENTS

18 NAME OF FATHER John Barker

19 BIRTHPLACE OF FATHER (City) Marlboro (State or country) Mass

20 MAIDEN NAME OF MOTHER Etta Temple

21 BIRTHPLACE OF MOTHER (City) Marlboro (State or country) Mass

22 Informant Mrs. Frank Horn
(Address) Shrewsbury, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Bd of Health March 7, 1958
(Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

10

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Girl Hamel (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Boston Rd. St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death .....years .....months .....days. In place of residence .....years .....months .....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 27, 1958 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Stillborn, 19....., to....., 19.....

I last saw h.....alive on....., 19....., death is said to have occurred on the date stated above, at 8.06P.M.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Stillborn macerated fetus.	
ANTECEDENT CAUSES Due To (b) Placental sclerosis.	Not known
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis? Pathologist Examination

5 Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) H. Joseph C. Merriam, M. D.

(Address) Framingham Date 3/18/58

6 Rural Cemetery Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 28, 1958 19.....

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St., Southboro

Received and filed April 10, 1958 19.....

Joseph F. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	white	single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here. Stillborn

12 AGE .....Years .....Months .....Days | If under 24 hours .....Hours .....Minutes

13 Usual Occupation:.....
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) (State or country) Framingham, Mass.

PARENTS

17 NAME OF FATHER Charles Francis Hamel

18 BIRTHPLACE OF FATHER (City) Somerville, (State or country) Mass.

19 MAIDEN NAME OF MOTHER Eleanor J. Onthank

20 BIRTHPLACE OF MOTHER (City) Framingham, (State or country) Mass.

21 Informant Charles F. Hamel
(Address) Boston Rd., Southboro

A TRUE COPY
ATTEST: .....
(Registrar of City or Town where death occurred)

March 28, 1958
DATE FILED .....19.....

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

9

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County) — Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Richard E. Carroll
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Cordaville Rd St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 14 days. In place of residence 4 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 28, 1958
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July, 1957, to March 28, 1958

I last saw him alive on March 28m 1958 death is said to have occurred on the date stated above, at 4/10p m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma of colon	1 yr
ANTECEDENT CAUSES (b) Due To	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Metastases to lungs & brain & liver	3 ms

Major findings: Of operations. carcinona of colon with liver metastases
Date of operation July 195? Was autopsy performed? no
What test confirmed diagnosis? path exam

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Lee G. Kendall M. D.
(Address) Framingham Date 3/29/58 19

6 Rural Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 31, 1958 19

7 NAME OF FUNERAL DIRECTOR T.F.Callanan & Son
ADDRESS Hopkinton

Received and filed April 2, 1958 19
Austin E. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
m	w	mar

10a If married, widowed or divorced HUSBAND of Annette Quinn
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 67 Years 2 Months 4 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Shipping clerk
(Kind of work done during most of working life)

14 Industry or Business: Carpet factory

15 Social Security No 019-10-2104

16 BIRTHPLACE (City) Framingham
(State or country) Mass.

PARENTS

17 NAME OF FATHER John F. Carroll

18 BIRTHPLACE OF FATHER (City) Framingham
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Agnes Cass

20 BIRTHPLACE OF MOTHER (City) Framingham
(State or country) Mass.

21 Informant Mrs. Richard E. Carroll
(Address) Southboro

A TRUE COPY
ATTEST: Francis J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED April 1, 1958 19

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires Physicians to print or type the cause or causes of death on death certificates.

100M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 86

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

No. Oak Hill Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mrs. Ada J. (Emmott) Berry
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) XXXXX

(a) Residence. No. Oak Hill Road (Usual place of abode) St. Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death 30 years ..... months ..... days. In place of residence 30 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 30 (Day) 1958 (Year)

4 I HEREBY CERTIFY, That I attended deceased from MARCH 30, 1958, to ....., 19....

I last saw her alive on MARCH 30, 1958 death is said to have occurred on the date stated above, at 8:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) CORONARY THROMBOSIS — 1 HOUR

Due To (b) ARTERIOSLEROTIC HEART DISEASE — 3 Months

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No If so, specify.....

(Signed) Marilyn Meserve, M. D.

(Address) Southboro, Mass Date March 30 1958

6 Wyoming Cemetery Melrose, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 1, 1958

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed 4-1 1958

Austin E Kelly Town Clerk
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): widowed

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Eugene F Berry
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years 6 Months 21 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) Wakefield
(State or country) Mass

PARENTS

17 NAME OF FATHER Joseph F. Emmott

18 BIRTHPLACE OF FATHER (City) CNBL
(State or country) England

19 MAIDEN NAME OF MOTHER Clair Wiles

20 BIRTHPLACE OF MOTHER (City) CNBL
(State or country) England

21 Informant Mrs. Grace Edmands
(Address) Oak Hill Rd Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Austin E Kelly
(Signature of Agent of Board of Health or other)

Town Clerk 3-31-58
(Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

11

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME WALTER IRVING BADGER III (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Residence. No. St. Mark's School St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ..... years ..... months 5 days. In place of residence 15 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 3, 1958 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 30, 1958, to April 3, 1958

I last saw him alive on April 3, 1958, death is said to have occurred on the date stated above, at ..... m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Peritonitis	8 das
ANTECEDENT CAUSES Due To (b) Ruptured diverticulitis.	8 das
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation..... Was autopsy performed? Yes.

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? no.

If so, specify.....

(Signed) Lee G. Kendall M. D.

(Address) Framingham Date Apr. 4 1958

6 Newton Crematory - Newton
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 8, 1958

7 NAME OF FUNERAL DIRECTOR Robert K. Wadsworth

ADDRESS 108 Lincoln St. Framingham

Received and filed April 10, 1958

Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	Married

10a If married, widowed, or divorced HUSBAND of Linda Main (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 39 Years 11 Months 13 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Teacher (Kind of work done during most of working life)

14 Industry or Business: St. Mark's School Southboro

15 Social Security No. 018-26-4681

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER William Irving Badger, Jr.

18 BIRTHPLACE OF FATHER (City) Cambridge, (State or country) Mass.

19 MAIDEN NAME OF MOTHER Jane Whitman Bullard

20 BIRTHPLACE OF MOTHER (City) Brookline, (State or country) Mass.

21 Informant Mrs. Linda Badger, (Wife)
(Address) St. Marks School, Southboro

A TRUE COPY

ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED April 8, 1958

6/24/42

5/13/43

Corporal

Co. E MAC OCS

31-136-152

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

12

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Floreda P. Derby (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Southville Rd. St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 13, 1958 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 12, 1958, to April 13, 1958

I last saw her alive on April 13, 1958, death is said to have occurred on the date stated above, at 3:30 P. m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a)	Acute Cholecystitis	48 hrs.
ANTECEDENT CAUSES (b) Due To		
(c) Due To		
OTHER SIGNIFICANT CONDITIONS	Chronic Myocardial Infarction.	?

Major findings: Of operations .....

Date of operation ..... Was autopsy performed? Yes.

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? No.

If so, specify .....

(Signed) Eugene A. Gaston 4/14, M. D.

(Address) Framingham Date 1958

6 Old Cemetery Ashburnham, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL ..... 19 .....

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS 62 W. Main St., Westboro

Received and filed April 15, 1958

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	white	Widowed

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Warren Derby (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 89 Years 11 Months 19 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: Own Home.

15 Social Security No. None.

16 BIRTHPLACE (City) Fitchburg, (State or country) Mass.

PARENTS

17 NAME OF FATHER Elisha A. Bruce

18 BIRTHPLACE OF FATHER (City) Leominster, (State or country) Mass.

19 MAIDEN NAME OF MOTHER Raphela P. Unina

20 BIRTHPLACE OF MOTHER (City) St. Augustine, (State or country) Florida

21 Informant Burton B. Derby (Address) Southville Rd. Southville

A TRUE COPY
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED April 15, 1958

FORM R-301A

Suffolk

Middlesex (County)

1 PLACE OF DEATH Boston, Mass. (City or Town)

No. Robert B. Brigham Hospital St. (If death occurred in a hospital or institution give its NAME instead of street and number)

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN 18

To be filed for burial permit with Board of Health or its Agent

Registered No. [illegible]

2 FULL NAME (Mr.) Sanford S. Mitchell
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southboro, Box 278, Massachusetts St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ___ years ___ months 7 days. In place of residence ___ years ___ months ___ days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

162.1

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires Physicians to print or type the cause or causes of death on death certificates.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 21, (Day) 1958 (Year)

4 I HEREBY CERTIFY That I attended deceased from Sept 24, 1956 to May 21, 1958

I last saw him alive on May 21, 1958, death is said to have occurred on the date stated above, at 7.55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchiogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 Mos.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Coronary Artery Disease

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify No.

(Signed) Theodore Feldman, M. D.

(Address) 454 Brookline Ave. Boston (Date) 6-21-58

6 MT HOPE BANGOR MAINE
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 25 1958

7 NAME OF FUNERAL DIRECTOR DONALD C MORRIS

ADDRESS MAIN ST SOUTHBORO MASS

Received and filed MAY 27 1958 Charles H. Mackie (Registrar)

Sept 17, 1958 E E Kelley

Change Cemetery

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced HUSBAND of Grace Coombs (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 9 Months 16 Days. If under 24 hours ___ Hours ___ Minutes

13 Usual Occupation: Civil engineer (Kind of work done during most of working life)

14 Industry or Business: CIVIL ENGINEER

15 Social Security No. 025-18-6366

16 BIRTHPLACE (City) (State or country) Cherryfield, Maine

PARENTS

17 NAME OF FATHER Otis Mitchell

18 BIRTHPLACE OF FATHER (City) (State or country) STUEBEN MAINE

19 MAIDEN NAME OF MOTHER Belle McNamara

20 BIRTHPLACE OF MOTHER (City) (State or country) STUEBEN MAINE

21 Informant MRS PAMELIA L. DICKSON
(Address) N MAIN ST. SOUTHBORO MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

N MacDonald (Signature of Agent of Board of Health or other)

7824 (Official Designation)

5-22-58 (Date of Issue of Permit)

50M-11-56-918978

14

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(c)-11-49-900.475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Marlboro (City or town making return)

Registered No. .....

PLACE OF DEATH

1 Middlesex (County)

Marlboro (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles G. Wiles (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. Learned St. St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 6 (Month) 9 (Day) 58 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Cerebral hemorrhage

5 Accident, suicide, or homicide (specify) No

Date and hour of injury ..... 19 .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? No Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Kenneth R. Greenleaf, M. D.

(Address) Marlboro Date 6/10, 58

Rural Cemetery, Southboro, Mass. Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL June 12 19 58

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St., Southboro, Mass.

Received and filed July 16, 1958 19 .....

Dunc. E. Reedy (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	White	Married

11a If married, widowed, or divorced HUSBAND of Lillian M. Johnson (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 72 Years 5 Months 5 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Carpenter (Kind of work done during most of working life)

15 Industry or Business: Building

16 Social Security No. 033-01-1040

17 BIRTHPLACE (City) Hanscounty (State or country) N.S. Canada

PARENTS

18 NAME OF FATHER Irving Wiles

19 BIRTHPLACE OF FATHER (City) Hanscounty (State or country) N.S. Canada

20 MAIDEN NAME OF MOTHER CNBL

21 BIRTHPLACE OF MOTHER (City) Hanscounty (State or country) N.S.Canada

22 Informant Mrs. Charles G. Wiles (Address) Learned St., Southboro, Mass.

A TRUE COPY

ATTEST: Emma L. Dunn (Registrar of City or Town where death occurred)

DATE FILED June 10, 19 58

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

12

Framingham (City or town making return)

Registered No.

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Susie (nee Brewer) Smith (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. Turnpike St. Southboro (If nonresident, give city or town and State) (Usual place of abode)

Length of stay: In place of death ..... years ..... months 24 days. In place of residence 69 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 29 (Day) 1958 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6-6- , 1958, to 6-29 , 1958

I last saw her alive on 6-28 , 1958, death is said to have occurred on the date stated above, at 9 a. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral hemorrhage	24"
ANTECEDENT CAUSES Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Diabetes Mellitis	10 yr

Major findings: Of operations.....

Date of operation..... Was autopsy performed? Yes

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) Mark S. Wellington, M. D.

(Address) Framingham Date 6-30 1958

6 Rural Cem. Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 1 1958

7 NAME OF FUNERAL DIRECTOR Richard P. Coldwell

ADDRESS 21 Cotting Ave., Marlborough

Received and filed July 11, 1958

Clinton E. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	White	Married

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Erwin Lee Smith
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years 8 Months 21 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Southboro (State or country) Mass.

PARENTS

17 NAME OF FATHER Nahaum F. Brewer

18 BIRTHPLACE OF FATHER (City) C.B.L. (State or country)

19 MAIDEN NAME OF MOTHER Mary S. Barnard

20 BIRTHPLACE OF MOTHER (City) Orland (State or country) Maine

21 Informant Mr. Erwin L. Smith
(Address) Turnpike St., Fayville

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED July 1 1958

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

15

Registered No. .....

1 PLACE OF DEATH: Middlesex (County) — Marlboro (City or Town) — Marlboro (City or Town making this return)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Oliver P. LaCroix (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. (Usual place of abode) A Street St. Southboro (If nonresident, give city or town and State)

Length of stay: In place of death .....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 25, 1958 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 17, 1958 to July 25, 1958

I last saw him alive on July 25, 1958, death is said to have occurred on the date stated above, at 10:50A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Coronary Thrombosis	July 17, 1958
Due To (b)	Coronary Sclerosis	?
Due To (c)	General Arteriosclerosis	?
OTHER SIGNIFICANT CONDITIONS	Lobar Pneumonia	7/17/58

Was autopsy performed? No
What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify.....

(Signed) N. John Colombo, M. D.
(Address) 39 Church St., Hudson, Mass. Date July 27, 1958

6 Rural Cemetery, Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 28, 1958

7 NAME OF FUNERAL DIRECTOR John P. Rowe
ADDRESS Marlboro, Mass.

Received and filed August 14, 1958
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced
HUSBAND of Dione Baker (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 58 Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Tractor Driver (Kind of work done during most of working life)

14 Industry or Business State-Mental Health Dept.

15 Social Security No. 019-10-7953

16 BIRTHPLACE (City) West Boylston (State or country) Mass.

PARENTS

17 NAME OF FATHER Antonio LaCroix

18 BIRTHPLACE OF FATHER (City) West Boylston (State or country) Mass.

19 MAIDEN NAME OF MOTHER Elice Chabot

20 BIRTHPLACE OF MOTHER (City) Marlboro (State or country) Mass.

21 Informant Mrs. Oliver P. LaCroix
(Address) A Street, Southboro

A TRUE COPY
ATTEST: Emma L. Dana
(Registrar of City or Town where death occurred)

DATE FILED July 30, 1958

17

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(c)-11-49-900.475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: Middlesex (County) — Marlboro (City or Town) — Marlboro (City or town making return)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Richard Hubley (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) 0

(a) Residence. No. Southville Road St. Southville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 45 days. In place of residence ..... years ..... months 45 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 8 (Month) 30 (Day) 58 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Interstitial pneumonitis

5 Accident, suicide, or homicide (specify) No

Date and hour of injury ..... 19 .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Kenneth R. Greenleaf, M. D.

(Address) Marlboro Date 8/30, 58

7 Eastwood Cemetery, Lancaster, Mass. Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Sept. 1 19 58

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St., Southboro, Mass.

Received and filed Sept 12 1958 19 .....

Custus E. Kelly

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	White	Single

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE ..... Years ..... Months 45 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: ..... (Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. .....

17 BIRTHPLACE (City) Marlboro (State or country) Mass.

PARENTS

18 NAME OF FATHER Alvah F. Hubley, Jr.

19 BIRTHPLACE OF FATHER (City) Framingham (State or country) Mass.

20 MAIDEN NAME OF MOTHER Martha Funderburk

21 BIRTHPLACE OF MOTHER (City) Clinton (State or country) Mass.

22 Informant Alvah F. Hubley, Jr. (Address) SouthvilleRoad., Southville, Mass.

A TRUE COPY.
ATTEST: Emma L. Dunn
(Registrar of City or Town where death occurred)

DATE FILED 9/5, 19 58

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-5-52-907046

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16

Registered No. 164

Westborough
(City or town making return)

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town); No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edward James McEnelly (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. E. Main St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 4 months 20 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 31, (Day) 1958 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arteriosclerotic Heart Disease

Pulmonary Tuberculosis

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury April 5 19 57

Where did Injury occur? Southboro, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? At home (Specify type of place)

Manner of Injury Due to a fall (How did injury occur?)

Nature of Injury Fracture rt. hip

While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Walter F. Mahoney M. D.

(Address) Westborough, Mass. Date Aug. 31 19 58

7 Place of Burial, or Cremation. St. Mary's (City or Town) Milford, Mass.

DATE OF BURIAL Sept. 3, 19 58

8 NAME OF FUNERAL DIRECTOR Charles M. Heroux

ADDRESS 10 Prentice Ave., Milford, Mass

Received and filed Sept 5 19 58

Annie A. Dunne
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male

10 COLOR OR RACE White

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

11a If married, widowed or divorced HUSBAND of Mae (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 78 Years Months Days

If under 24 hours Hours Minutes

14 Usual Occupation: Musician (Kind of work done during most of working life)

15 Industry or Business: no

16 Social Security No.

17 BIRTHPLACE (City) Spencer, (State or country) Mass.

PARENTS

18 NAME OF FATHER Thomas McEnelly

19 BIRTHPLACE OF FATHER (City) Milford, (State or country) Mass.

20 MAIDEN NAME OF MOTHER Mary Keefe

21 BIRTHPLACE OF MOTHER (City) Milford, (State or country) Mass.

22 Informant Westborough State Hospital Records (Address)

A TRUE COPY.

ATTEST: Annie A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED Sept. 5, 19 58

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 8365

1 PLACE OF DEATH: Suffolk (County) — Boston (City or Town)

No. 424 Dudley Street, Roxbury St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Kelleher (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Road, Southville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires Physicians to print or type the cause or causes of death on death certificates.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept (Month) 1 (Day) 1958 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 5, 1958 to Sept 1, 1958

I last saw her alive on Sept 1, 1958, death is said to have occurred on the date stated above, at 3 P m.

DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
(a)	
Due To (b) Cerebral Thrombosis	1 day
Due To (c) Arterio Sclerosis	Few years
OTHER SIGNIFICANT CONDITIONS: Old age	

Was autopsy performed? .....
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) Lewis Harnett, M. D.
(Address) 222 Bowdoin St. Date Sept 1 1958

6 Place of Burial or Cremation: New Calvary Cemetery (City or Town) Boston
DATE OF BURIAL Sept. 5, 1958 19

7 NAME OF FUNERAL DIRECTOR P. E. Murray Fun. Serv
ADDRESS 54 Roxbury St., Roxbury

Received and filed SEP 5 1958 19
(Registrar) Charles A. Mackie

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Married

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of John Kelleher (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. [illegible]

16 BIRTHPLACE (City) Ireland (State or country)

PARENTS

17 NAME OF FATHER William Connolly

18 BIRTHPLACE OF FATHER (City) Ireland (State or country)

19 MAIDEN NAME OF MOTHER Bridget CNBI

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant (Address) Mrs. John F. Farricy, Southville Rd., Southville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

9-2-58 (Official Designation) 9-3-58 (Date of Issue of Permit)

100M-11-58-91648

Room offer
November 29
1958
Q E Kelly

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

23

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Marlboro (City or Town); Marlboro (City or Town making this return)

No. Marlboro Hospital St. ((If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Olive L. Houghton (Sawin)(Blanding) (Was deceased a U. S. War Veteran, if so specify WAR).....
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. Cordaville Road Cordaville, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 11, 1958
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from September 6 1958 to September 11 1958
I last saw her alive on September 11, 1958, death is said to have occurred on the date stated above, at 11:15AM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Arteriosclerotic Heart Disease — 5 yrs.

Due To
(b) Generalized Arterio-sclerosis — 10 yrs.

Due To
(c) .....

OTHER SIGNIFICANT CONDITIONS .....

Was autopsy performed? No
What test confirmed diagnosis? EKG

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify.....

(Signed) John Paul Ahearn, M. D.
(Address) Marlboro, Mass. Date 9/11, 1958

6 North Cemetery, Princeton, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL September 13, 1958

7 NAME OF FUNERAL DIRECTOR Silas F. Richardson
ADDRESS 106 West St., Leominster

Received and filed Oct 10, 1958 19.....
Austin E. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
F	W	Married

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Herbert Houghton
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years 5 Months 22 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation:.....
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Athol
(State or country) Mass.

PARENTS

17 NAME OF FATHER Oscar Blanding

18 BIRTHPLACE OF FATHER (City) Cannot be learned
(State or country)

19 MAIDEN NAME OF MOTHER Laura

20 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country)

21 Informant Wesley E. Sawin
(Address) Cordaville, Mass.

A TRUE COPY
ATTEST: Emma L. Dunn
(Registrar of City or Town where death occurred)

DATE FILED September 12, 1958

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Boylston
(City or town making return)

Registered No. .....

1 PLACE OF DEATH
Worcester (County)
Boylston (City or Town)
No. WORCESTER COUNTY SANATORIUM St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Anthony Sears
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. Southville Rd. Cordaville St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 10 years 13 months ... days. In place of residence 25 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 16, 1958.
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1957, to Sept. 16, 1958
I last saw him alive on Sept. 16, 1958 death is said to have occurred on the date stated above, at 12.20 p. m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Infarction	2 mos.
ANTECEDENT CAUSES (b) Due To	
(c) Due To	
OTHER SIGNIFICANT CONDITIONS Tuberculosis of lung far advanced, active	6 yrs.

Major findings: Of operations.....
Date of operation..... Was autopsy performed? No
What test confirmed diagnosis? X-Ray + Laboratory

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify.....
(Signed) Heinz J. Lorge M. D.
(Address) Wor. Co. San. Date 9/16 1958

6 Rural Cemetery South Boro, Ms.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL September 19, 1958

7 NAME OF FUNERAL DIRECTOR John W Sullivan
ADDRESS 378 Lincoln St., Marlboro, Ms.

Received and filed Oct. 3, 1958 19...
Custis E. Kelly T.C.
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced
HUSBAND of Katherine Toomey
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years 4 Months 1 Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation Cafeteria Helper
(Kind of work done during most of working life)

14 Industry or Business: Restaurants

15 Social Security No. 013-18-1919

16 BIRTHPLACE (City) (State or country) Chicopee Mass

PARENTS

17 NAME OF FATHER William J. Sears

18 BIRTHPLACE OF FATHER (City) (State or country) Chicopee Mass.

19 MAIDEN NAME OF MOTHER Johanna Kennedy

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant (Address) Worcester Co. Hospital Records

A TRUE COPY
ATTEST: Harold B. French
(Registrar of City or Town where death occurred)

DATE FILED September 17, 1958.

21

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Westborough
(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH
Worcester
(County)
Westborough
(City or Town)
No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Hattie M. Melendy
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Ward Rd. St. x Southborough, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 9 months 1 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 17, 1958
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug. 17 er, 19 58 to Sept. 17, 19 58
I last saw h alive on Sept. 17, 19 58, death is said to have occurred on the date stated above, at ..... m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Coronary Occlusion

Due To
(b) Arteriosclerotic Heart Disease

Due To
(c) .....

OTHER SIGNIFICANT CONDITIONS .....

Was autopsy performed? No
What test confirmed diagnosis? Clinical Findings

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) ....., M. D.
(Address) Westboro, Mass. Date 9/17/ 19 58

6 Main St. Cem. Hudson, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL September 19, 19 58

7 NAME OF FUNERAL DIRECTOR John A. Kennedy
ADDRESS Hudson, Mass.

Received and filed Oct 10, 1958 19 .....
Austin E. Kelly T. C.
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED Widow or DIVORCED (write the word)

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Arthur I. Melendy
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. 012-30-3166D

16 BIRTHPLACE (City) Enfield, (State or country) N.H.

PARENTS

17 NAME OF FATHER William MacConnell

18 BIRTHPLACE OF FATHER (City) Cannot be learned (State or country) .....

19 MAIDEN NAME OF MOTHER Annie Wilson

20 BIRTHPLACE OF MOTHER (City) Cannot be learned (State or country) .....

21 Informant Westborough State Hospital
(Address) Records

A TRUE COPY
ATTEST: Annie A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED September 19, 19 58

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

19

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Agnes M (Girard) Hamelin
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Winchester St. St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 10 days. In place of residence 15 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. (Month) 19 (Day) 1958 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1954, to Sept. 19, 1958

I last saw her alive on Sept. 19, 1958, death is said to have occurred on the date stated above, at 11:35 a.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral thrombosis.	6 hrs.
ANTECEDENT CAUSES Due To (b) Cerebral & General Arteriosclerosis.	yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS immobilization due to hip fracture.	19 das.

Major findings:
Of operations.....
Date of operation..... Was autopsy performed? No.
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify.....
(Signed) Timothy P. Stone, M. D.
(Address) Southboro Date 9/20 19 58

6 St. Mary's Cemetery - Marlboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Sept. 22 19 58

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St., Southboro, Mass.

Received and filed Oct 1, 1958
Dorothy C. Ladd
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	W	Wid

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Milford W. Hamelin
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years 1 Months 20 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home.

15 Social Security No. None.

16 BIRTHPLACE (City) St. Jaques (State or country) Canada

PARENTS

17 NAME OF FATHER Alexia Girard

18 BIRTHPLACE OF FATHER (City) C.N.B.L. (State or country) Canada

19 MAIDEN NAME OF MOTHER Odile Longton

20 BIRTHPLACE OF MOTHER (City) C.N.B.L. (State or country) Canada

21 Informant Walter Hamelin
(Address) Winchester St., Southboro

A TRUE COPY
ATTEST: Dorothy C. Ladd
(Registrar of City or Town where death occurred)

DATE FILED September 22, 19 58.

22

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-5-52-907046

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Westborough
(City or town making return)

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town); No. ..... Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Angela Sclavunos
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Turnpike Rd. St. x Fayville, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 7 years 0 months 22 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 22, 1958
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Asphyxiation by Aspiration of piece of meat.

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury Sept. 22, 19 58
Where did Injury occur? Westborough, Mass.
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? State Hospital
(Specify type of place)
Manner of Injury Swallowed piece of meat
(How did injury occur?)
Nature of Injury Asphyxiation
While at work? No Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Walter F. Mahoney M. D.
(Address) Westboro, Mass. Date 9/22/ 19 58

7 Place of Burial, or Cremation Rural Cemetery, Southboro, Mass.
DATE OF BURIAL September 25, (City or Town) 19 58

8 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Southboro, Mass.

Received and filed OCT 6, 1958 19 .....
Austin E. Keeley JC
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Married

11a If married, widowed, or divorced HUSBAND of Stephen Sclavunos
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 37 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. .....

17 BIRTHPLACE (City) (State or country) Southboro, Mass.

PARENTS

18 NAME OF FATHER Charles Brusie

19 BIRTHPLACE OF FATHER (City) (State or country) Italy

20 MAIDEN NAME OF MOTHER Caroline Bertonazzi

21 BIRTHPLACE OF MOTHER (City) (State or country) Italy

22 Informant Westborough State Hospital Records
(Address)

A TRUE COPY.
ATTEST: Annie A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED September 30, 19 58

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

24

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James P. Stacey (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Learned St. St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 2 months ..... days. In place of residence 21 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 6 1958 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Mar. 16 53, to Oct. 6, 1958

I last saw him alive on Oct. 6, 1958, death is said to have occurred on the date stated above, at 4:20P m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma, bladder urinary — INTERVAL BETWEEN ONSET AND DEATH: 8 Mos. plus

ANTECEDENT CAUSES Due To (b) .....

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS No.

Major findings: Of operations.....

Date of operation..... Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? No. If so, specify.....

(Signed) Timothy P. Stone M. D.

(Address) Southboro Date 10/8/1958

6 Rural Cemetery - Southboro Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 9, 1958

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed October 9, 1958

Austin E. Kelly T.C. (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR OR RACE: white

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Marr.

10a If married, widowed, or divorced HUSBAND of Rhoda E. Kennedy Gray (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 71 Years 10 Months 15 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Marine Engineer (Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No. 023-09-4807

16 BIRTHPLACE (City) (State or country) Phippsburg, Maine

PARENTS

17 NAME OF FATHER: George Stacey

18 BIRTHPLACE OF FATHER (City) (State or country) Bath, Maine

19 MAIDEN NAME OF MOTHER: Sarah Ricketts

20 BIRTHPLACE OF MOTHER (City) (State or country) England

21 Informant Mrs. Rhoda E.K.GrayStacey (Address) Learned St. Southboro

A TRUE COPY

ATTEST: ..... (Registrar of City or Town where death occurred)

DATE FILED October 10, 1958

FORM R-301A

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - 6 TOWN
To be filed for burial permit with Board of Health or its Agent.

Registered No. 10621

1 PLACE OF DEATH
Suffolk (County)
Boston (City or Town)
No. Little Sisters of The Poor Dudley St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John Kelleher
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Road, Southville, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ...... years ...... months ...... days. In place of residence ...... years ...... months ...... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

Note:- Chapter 137, Acts of 1954, requires Physicians to print or type the cause or causes of death on death certificates.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov (Month) 12 (Day) 1958 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1958, to Nov 12, 1958
I last saw him alive on Nov 11, 1958, death is said to have occurred on the date stated above, at 11 A m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Congestive Heart Failure	2 days
ANTECEDENT CAUSES Due To (b)	Sclerotic Heart	Few months
Due To (c)	Arterio Sclerosis	Few years
OTHER SIGNIFICANT CONDITIONS	Old Age	

Major findings: Of operations ......
Date of operation ...... Was autopsy performed? ......
What test confirmed diagnosis? ......

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify ......
(Signed) E. Lewis Harnett M. D.
(Address) 72 Bowdoin St Date Nov 13 1958

6 New Calvary Cemetery Boston
Place of Burial or Cremation (City or Town)
DATE OF BURIAL November 15, 1958 19...

7 NAME OF FUNERAL DIRECTOR P. E. Murray Fun. Service
ADDRESS 54 Roxbury St., Roxbury

Received and filed NOV 18 1958 19...
Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male
9 COLOR OR RACE White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced HUSBAND of Mary E. Connolly
(Give maiden name of wife in full)
(or) WIFE of ......
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 90 Years ...... Months ...... Days. If under 24 hours ...... Hours ...... Minutes

13 Usual Occupation: Hotel Work Ret.
(Kind of work done during most of working life)

14 Industry or Business: Parker House

15 Social Security No. None

16 BIRTHPLACE (City) Ireland
(State or country)

PARENTS
17 NAME OF FATHER Daniel Kelleher
18 BIRTHPLACE OF FATHER (City) Ireland (State or country)
19 MAIDEN NAME OF MOTHER Elizabeth Murphy
20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant Mrs. John Farricy
(Address) Southville Rd., Southville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
[signature]
(Signature of Agent of Board of Health or other)
42 (Official Designation) 11-13-58 (Date of Issue of Permit)

50M-5-55-915025

Received + filed Feb 4, 1959 - Austin ... Town Clerk -

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

27

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: Middlesex (County) — Marlborough (City or Town) — Marlborough (City or Town making this return)

No. Marlborough Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anna Bothilda (Autzen) Moore (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Newton St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 wks. years months days In place of residence 47 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 19, 1958 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1958 to Nov. 19, 1958

I last saw her alive on Nov. 19 1958, death is said to have occurred on the date stated above, at 4:50 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

Due To (b) Gen. Arteriosclerosis — 20 yrs.

Due To (c) --

OTHER SIGNIFICANT CONDITIONS: None

Was autopsy performed? No

What test confirmed diagnosis? Phys. Exam

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) William D. Roche, M. D.

(Address) Marlboro, Mass. Date 11/20, 58

6 Wilson Cem., Marlborough Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 22, 1958

7 NAME OF FUNERAL DIRECTOR Richard P. Coldwell

ADDRESS 21 Cotting Ave., City

Received and filed December 3, 1958

Anthis Kelly T.C. (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced HUSBAND of..... (Give maiden name of wife in full)

(or) WIFE of Guy Tremeer Moore (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 89 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: --

15 Social Security No.....

16 BIRTHPLACE (City) (State or country) Jordjer Denmark

PARENTS

17 NAME OF FATHER Christian J. Autzen

18 BIRTHPLACE OF FATHER (City) Nybel (State or country) Denmark

19 MAIDEN NAME OF MOTHER Anna Jorgensen

20 BIRTHPLACE OF MOTHER (City) C.B.L. (State or country) Denmark

21 Informant (Address) Mrs. Ulderic Hurley Newton St., Southboro

A TRUE COPY ATTEST: Emma L Dunn (Registrar of City or Town where death occurred)

DATE FILED November 24, 1958

50M.11-55-916145

25

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec 12, G. L.)

25M-3-53-909098

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH

Middlesex (County)

Framingham (City or Town)

Framingham (City or town making return)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elizabeth Ann Ross
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Cordaville Rd. St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death .....years .....months .....days. In place of residence .....years .....months .....days.
21 hrs. 5 min.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 20 1958
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1958, to Nov. 20, 1958

I last saw her alive on Nov. 20, 1958 death is said to have occurred on the date stated above, at 4:30a m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Brain damage

ANTE CEDENT CAUSES Due To (b) Cerebral anoxia (cord accident)

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS .....

INTERVAL BETWEEN ONSET AND DEATH

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) Jean C. Avery M. D.
(Address) 154 Union Ave. Date 11/20, 1958

6 Rural Cemetery Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL November 21 1958

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro

Received and filed November 25 1958
Austin E. Kelly
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE .....Years .....Months .....Days If under 24 hours 21 Hours 5 Minutes

13 Usual Occupation: None
(Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City) Framingham
(State or country) Mass.

PARENTS

17 NAME OF FATHER William L. Ross Jr.

18 BIRTHPLACE OF FATHER (City) Framingham
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Jane Flynn

20 BIRTHPLACE OF MOTHER (City) Marlboro
(State or country) Mass.

21 Informant William L. Ross Jr.
(Address) Cordaville Rd. Southboro

A TRUE COPY.
ATTEST: W. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED Nov. 21 1958

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK -- THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

28

HUDSON (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH
Middlesex (County)
Hudson (City or Town)
No. Hudson Hospital St. ((If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mrs. Caroline (Bertonassi) Brusie
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) none

(a) Residence. No. Turnpike Road, St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 15 days. In place of residence 52 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 3. (Day) 1958 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 19 58 to Dec. 3, 19 58
I last saw her alive on Dec. 3, 19 58, death is said to have occurred on the date stated above, at 11:50A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Chronic Myocarditis	1yr.
Due To (b)	Essential Hypertension	10 yrs.
Due To (c)	Diabetes Mellitus	15 yrs.
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? no
What test confirmed diagnosis? Physical examination

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signed) Peter P. Cottone, M. D.
(Address) 75 W. Main St. Marlborough Date Dec. 4, 19 58

6 Rural Cemetery Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 6, 19 58

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St., Southboro, Mass.

Received and filed Dec. 24, 1958 19 59
Arthur Keely Town Clerk
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Married

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Charles Brusie
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years 5 Months 15 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. none

16 BIRTHPLACE (City) Piacenza
(State or country) Italy

PARENTS

17 NAME OF FATHER Peter Bertonassi

18 BIRTHPLACE OF FATHER (City) Piacenza
(State or country) Italy

19 MAIDEN NAME OF MOTHER CNBL

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) Italy

21 Informant Charles Brusie
(Address) Turnpike Rd., Southboro, Mass.

A TRUE COPY
ATTEST: Ralph W. Warner
(Registrar of City or Town) ecurred)

DATE FILED December 13, 1958 19 .....

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M.11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. .....

Marlboro (City or Town making this return)

1 PLACE OF DEATH: Middlesex (County); Marlboro (City or Town); No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lillian M. (Tucker) Pearse (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Newton St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 13, 1958 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1948 to Dec. 13, 1958

I last saw her alive on Dec. 12, 1958, death is said to have occurred on the date stated above, at 9:29 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

Due To (b) Arteriosclerosis — yrs.

Due To (c) —

OTHER SIGNIFICANT CONDITIONS: No

No

Was autopsy performed? Clinical

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify —

(Signed) Timothy P. Stone, M. D.

(Address) Southboro, Mass. Date Dec. 14, 1958

6 Rural, Southboro, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 15, 1958

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS 82 West Main St., Westboro, Mass.

Received and filed Jan 13, 1959 19....

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female | 9 COLOR: White | 10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widow

10a If married, widowed, or divorced HUSBAND of .....

(Give maiden name of wife in full)

(or) WIFE of John B. Pearse

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE: 77 Years 1 Months 10 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City or Town) Devonshire (State or country) England

PARENTS

17 NAME OF FATHER Thomas S. Tucker

18 BIRTHPLACE OF FATHER (City) Devonshire (State or country) England

19 MAIDEN NAME OF MOTHER Annie Willis

20 BIRTHPLACE OF MOTHER (City) Devonshire (State or country) England

21 Informant (Address) Mrs. Ada P. Taylor Newton St., Southboro, Mass.

A TRUE COPY ATTEST: ..... (Registrar of City or Town where death occurred)

DATE FILED December 17, 1958

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-11-55-916145

2

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Marlboro (City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Marlboro (City or Town); No. Blue Haven Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ida Gertrude McMaster (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. Oak Hill (Usual place of abode) St. (Fayville) Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death 3 years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 18, 1958 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1958 to Dec. 18, 1958

I last saw her alive on Dec. 18, 1958, death is said to have occurred on the date stated above, at 12: 10 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

Due To (b) Gen. Arteriosclerosis — 10 yrs.

Due To (c) ---

OTHER SIGNIFICANT CONDITIONS: Diabetes Mellitus — 10 yrs.

Was autopsy performed? No

What test confirmed diagnosis? Phys Exam

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) William D. Roche M. D.

(Address) Marlboro, Mass. Date 12/19, 1958

6 Place of Burial or Cremation Edson Cemetery, Lowell, Mass.

DATE OF BURIAL Dec. 20, (City or Town) 1958

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main Street, Southboro, Mass.

Received and filed Jan 13, 1959

(Registrar of City or Town where deceased resided) E. E. Kelly [illegible]

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE Years 01 Months 10 Days 18 — If under 24 hours Hours ..... Minutes

13 Usual Occupation: Clerical (Kind of work done during most of working life)

14 Industry or Business: U. S. Post Office & Domestic

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Lowell Mass.

PARENTS

17 NAME OF FATHER Lucas I. McMaster

18 BIRTHPLACE OF FATHER (City) Antrim (State or country) N.H.

19 MAIDEN NAME OF MOTHER Nancy Parker

20 BIRTHPLACE OF MOTHER (City) Augusta (State or country) Maine

21 Informant Miss Ruth Sawin
(Address) Oak Hill Rd., Southboro, Mass.

A TRUE COPY
ATTEST: Emma L Dunn
(Registrar of City or Town where death occurred)

DATE FILED December 22, 1958

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(c)-11-49-900.475

3

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Marlboro (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Marlboro (City or Town); No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Girl Cutter (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. Atwood Road (Usual place of abode) Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death 8 hrs. years months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 12 (Month) 23 (Day) 58 (Year) 10:35 P.M.

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Anoxia secondary to premature separation of placenta

5 Accident, suicide, or homicide (specify) Yes

Date and hour of injury 11:50 A.M. 12/23/ 1958

Where did Injury occur? Marlboro, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Public Street (Specify type of place)

Manner of Injury Mother's abdomen struck in auto (How did injury occur?)

Nature of Injury accident Separation of placenta

While at work? No Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Kenneth Greenleaf M. D.

(Address) Marlboro Date 12/25, 58

Place of Burial, or Cremation. Rural Cemetery, Southboro, Mass. (City or Town)

DATE OF BURIAL December 26, 58

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St., Southboro, Mass.

Received and filed Jan 13 1959 19

Justice E. Kelley, Asst Clerk

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: F

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE Years Months 8 hrs. Days 8 If under 24 hours Hours Minutes

14 Usual Occupation: Infant (Kind of work done during most of working life)

15 Industry or Business: None

16 Social Security No. None

17 BIRTHPLACE (City) (State or country) Marlboro Mass.

PARENTS

18 NAME OF FATHER Paul B. Cutter, Jr.

19 BIRTHPLACE OF FATHER (City) Melrose (State or country) Mass.

20 MAIDEN NAME OF MOTHER Alice King

21 BIRTHPLACE OF MOTHER (City) Des Moines (State or country) Iowa

22 Informant Paul B. Cutter, Jr. (Address) Atwood Road, Southboro, Mass.

A TRUE COPY.

ATTEST: ..... (Registrar of City or Town where death occurred)

DATE FILED December 29, 19 58

FORM R-301A

Jurisdiction waived by medical Examiner

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires Physicians to print or type the cause or causes of death on death certificates.

50M-1-58-921876

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN 5

To be filed for burial permit with Board of Health or its Agent.

Registered No. 1100 2228

1 PLACE OF DEATH: SUFFOLK (County); BOSTON (City or Town)

No. THE CHILDREN'S HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME EDWARD NEWTON
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. FRAMINGHAM ROAD St. SOUTHBORO, MASSACHUSETTS
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death HOSPITAL 13hrs; 20min. years months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DEC. 28 1958
(Month) (Day) (Year)

4 I HEREBY CERTIFY. That I attended deceased from DEC 27, 1958 to DEC. 28, 1958
I last saw him alive on DEC. 28, 1958, death is said to have occurred on the date stated above, at 2:50a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CONGENITAL HEART DISEASE	
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? Yes
What test confirmed diagnosis? CARDIAC CATHETERIZATION

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No

(Signed) David H. Smith. M. D.
(Address) 300 Longwood Date Dec. 28 1958

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Dec. 30 1958

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass.

Received and filed DEC 31 1958
Clarke H. Mackie
(Registrar)

Jan 31, 1959 Constance Kelly Donda

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
M	White	Single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 2 Years 8 Months 13 Days | If under 24 hours ___ Hours ___ Minutes

13 Usual Occupation: at home
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. None

16 BIRTHPLACE (City) Natick (State or country) Mass

PARENTS

17 NAME OF FATHER Edward W. Newton

18 BIRTHPLACE OF FATHER (City) Warwick (State or country) R.I.

19 MAIDEN NAME OF MOTHER Rita Stella

20 BIRTHPLACE OF MOTHER (City) Santa Rosa (State or country) Calif

21 Informant Edward W. Newton
(Address) Framingham Rd. Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

A Masiewicz E 16009
(Signature of Agent of Board of Health or other)

Dec 29 58
(Official Designation) (Date of Issue of Permit)